PriorityHealth

# Pharmacy
# Prior Authorization Form

New: Nov 11

**For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206**

**This form applies to: ☒ Commercial Plan ☒ Medicaid Plan ☒ Medicare Plan**

## Jevtana (carbazitaxel)

☐ Urgent ☐ Non-urgent

| Member Name: | Member #: |
|---|---|
| DOB: | Gender: |
| Provider Name: | Provider Phone: |
| Provider Office Address: | |
| Provider Office Contact Name: | Provider Fax: |
| Provider Signature: | Provider NPI: |
| Date: | Member's PCP: |

Product:

☒ Jevtana 60mg/1.5mL solution for intravenous administration

Dose: ______________________________ Start date: ____________________

Place of administration:

☐ Self-administered
☐ Provider's Office
☐ Outpatient Infusion Center Name of center: ______________________________
☐ Home Infusion Name of agency: ______________________________

Billing options:

☐ Physician buy and bill
☐ Preferred Specialty Vendor
☐ Other: ________________________________________________

### Priority Health Precertification Requirements:

**Authorization of Jevtana requires:**

- Diagnosis of hormone-refractory metastatic prostate cancer
- Prior use of a docetaxel-containing treatment regimen
- Serum prostate-specific antigen (PSA) ≥ 5 ng/mL
- Two sequential rising PSA levels obtained 2–3 weeks apart or other evidence of disease progression
- Eastern Cooperative Oncology Group (ECOG) performance status of 0-2
- Serum testosterone < 50 ng/dL
- Jevtana will not be authorized for patients with any of the following:
  - Congestive heart failure
  - Myocardial infarction within the last 6 months
  - Uncontrolled cardiac arrhythmias, angina pectoris, and/or hypertension
  - ECOG performance status ≥ 3

PriorityHealth

**Please Complete the Following Information:**

Diagnosis:
- ☐ Hormone refractory metastatic prostate cancer -ICD code: __________________
- ☐ Other: _____________________ ICD code: __________________
  Please provide rationale for use:
  ____________________________________________________________________________

ECOG performance status
- ☐ 0: Fully active, able to carry on all pre-disease performance without restriction
- ☐ 1: Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
- ☐ 2: Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours
- ☐ 3: Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours
- ☐ 4: Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair

Serum PSA levels: __________ ng/mL Date: ___________
__________ ng/mL Date: ___________

Serum testosterone level: __________ ng/mL Date: ___________

Patient has had a trial of Taxotere (docetaxel) every three weeks with steroids for 10 course:
- ☐ Yes
- ☐ No – Rationale: ____________________________________________

Jevtana will not be authorized for patients with any of the following (check which, if any, apply):

- ☐ Congestive heart failure
- ☐ Myocardial infarction within the last 6 months
- ☐ Uncontrolled cardiac arrhythmias, angina pectoris, and/or hypertension
- ☐ ECOG performance status ≥ 3

## FOR MEDICARE ONLY

**If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:**

1. ☐ All covered Part D drugs on any tier of a plan’s formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2. ☐ The number of doses available under a dose restriction for the prescription drug:
   - **a.** ☐ Has been ineffective in the treatment of the enrollee’s disease or medical condition, or
   - **b.** ☐ Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug’s effectiveness

or patient compliance.

3. ☐ The prescription drug alternative(s) listed on the formulary or required to be used in accordance
   with step therapy requirements:
   a. ☐ Has been ineffective in the treatment of the enrollee's disease or medical condition, or
   b. ☐ Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
   c. ☐ Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4. ☐ None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

*** All fields must be complete and legible for Prior Authorization Review***

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**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**