

Pharmacy

PRIOR AUTHORIZATION FORM

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

Sylatron[®] (peginterferon alfa-2b)

URGENT (life threatening)

Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature

Date

PRODUCT INFORMATION

- SYLATRON[®] 296 mcg injection
 SYLATRON[®] 444 mcg injection
 SYLATRON[®] 888 mcg injection

Dose: _____ **Start Date:** _____

BILLING INFORMATION

Place of administration:

- Self-administered
 Provider's Office
 Outpatient Infusion Center
 Center Name: _____
 Home Infusion
 Agency Name: _____

Billing Options:

- Physician buy and bill
 Preferred Specialty Vendor
 Other: _____

Request:

- New – Complete Section A
 Continuation – Complete Section B

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for SYLATRON[®] (peginterferon alfa-2b) requires the following information to certify:

Initial authorization for SYLATRON[®], limited to 8 weeks, requires:

1. Diagnosis of stage 3 malignant melanoma with positive microscopic or gross nodal involvement
2. SYLATRON[®] administration must begin within 84 days after cutaneous lesion is removed with documentation of adequate surgical margins and complete regional lymphadenectomy.
3. Patient must not have autoimmune hepatitis, or hepatic decompensation, or severe neuropsychiatric disorders.

Continued authorization for SYLATRON, given in 6 month intervals, requires:

1. The patient must not experience persistent or worsening severe neuropsychiatric disorders, grade 4 non-hematologic toxicity, or new or worsening retinopathy.
2. The patient must be able to tolerate a dose of at least 1 mcg/kg/week and not exceed doses greater than a maintenance dose of 3 mcg/kg/week.
3. The patient is compliant in taking the medication as scheduled
4. The patient tolerated the medication
5. The patient did not experience any severe adverse reactions while taking the medication
6. The patient has responded to treatment, as determined by the prescribing physician

Section A – NEW REQUEST

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for SYLATRON[®] (peginterferon alfa-2b) requires the following information to certify:

A. What is the patient's diagnosis?

- a. Malignant melanoma with positive microscopic or gross nodal involvement
 - i. Does the patient have histologically documented stage III melanoma?
 Yes
 No (authorization will not be given)
- b. Other: _____
rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

B. Did the patient have the primary cutaneous lesion removed with adequate surgical margins and complete regional lymphadenectomy?

- a. Yes
Date of surgery: _____

Note: SYLATRON must be started within 84 days of definitive surgical resection, including complete lymphadenectomy. Requests to start medication when a time period greater than 84 days after surgery has elapsed, authorization will not be given.

- b. No
Rationale for use: _____

C. Which of the following conditions does the patient have (conditions are contraindicated for use with SYLATRON[®] and authorization will not be given)?

- Autoimmune hepatitis
- Hepatic decompensation (Child-Pugh score > 6 [class B and C])
- None of the above

Section B – CONTINUATION REQUEST

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for continuation of SYLATRON[®] (peginterferon alfa-2b) requires the following information to certify:

Patient must have met the following requirements:

1. Has the patient experienced persistent or worsening severe neuropsychiatric disorders?

No
 Yes (authorized will not be given; use contraindicated)

2. Has the patient experienced grade 4 non-hematologic toxicity?

No
 Yes (authorized will not be given; use contraindicated)

3. Has the patient experienced new or worsening retinopathy?

No
 Yes (authorized will not be given; use contraindicated)

4. What dose will be administered (please give in mcg/kg/week)?

Dose: _____

Note: Doses less than 1 mcg/kg/week or greater than 3 mcg/kg/week will not be authorized for continuation. SYLATRON[®] should not be used in patients unable to tolerate at least a 1 mcg/kg/week dose. Maintenance dosing is recommended at 3 mcg/kg/week.

5. Select which of the following apply (all must be met for continuation of therapy):

The patient is compliant in taking the medication as scheduled
 The patient tolerated the medication
 The patient did not experience any severe adverse reactions while taking the medication
 The patient has responded to treatment, as determined by the prescribing physician

OTHER INFORMATION

Note: Initial authorization will be for 8 doses (1 injection every week for 8 weeks) to allow for 6 mcg/kg/week dosing followed by 3 mcg/kg/week dosing thereafter with recertification required every 6 months. SYLATRON is covered under the pharmacy benefit when the patient is self-injecting and the medical benefit if a healthcare provider is administering the injection.

PRIORITY MEDICARE PLANS (PART B)

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

FOR MEDICARE ONLY (PART D)

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***
Please fax this request to: (877)974-4411 toll free or (616)942-8206
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**