PriorityHealth

Pharmacy
PRIOR AUTHORIZATION FORM

Last Reviewed: January 2012
New: January 2012

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

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

Erwinaze® (asparaginase erwinia chrysanthemi)

☐ **URGENT** (life threatening)

☐ **Non-Urgent** (standard review)

A claim involving "urgent care" applies when then 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

☐ Ewrinaze 10,000 unit power for Injection

Dose: ____________________

Start Date: ____________________

BILLING INFORMATION

Place of administration:

☐ Provider's Office
☐ Outpatient Infusion Center
Center Name: ____________________
☐ Home Infusion
Agency Name: ____________________

Billing Options:

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

PriorityHealth

PRIORITY HEALTH PRECERTIFICATION REQUIRMENTS

Authorization for Erwinaze® (asparaginase erwinia chrysanthemi) requires the following information to certify:

Patient must have met the following requirements:

- Documented trial and clinical failure or inadequate response to Elspar™ or Oncaspar™

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for Erwinaze® (asparaginase erwinia chrysanthemi) requires the following information to certify:

A. Which of the following medications did the patient have a trial with?

a. ☐ Elspar (l-asparaginase Escherichia coli)
b. ☐ Oncaspar (pegasparagase)
c. ☐ *None of the above*
   ☐ Patient has a documented allergy to above medications, or
   ☐ *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, U.S. Pharmacopeia, 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.

PRIORITY MEDICARE PLANS

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.

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX