PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Adcetris® (brentuximab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phone: _____ Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New request ☐ Continuation request

Drug product: ☒ Adcetris 50 mg powder for injection

Dose (mg/kg): _____

Frequency: _____

Weight: _____

Date of last dose: _____

Date of next dose: _____

ICD-10 Diagnosis Code(s): _____

Administration:
☐ Physician's Office
☐ Outpatient Infusion
Facility: _____ NPI: _____ Fax #: _____
☐ Home infusion
Agency: _____ NPI: _____ Fax #: _____

Billing:
☐ Physician Buy and Bill
☐ Facility Buy and Bill
☐ Specialty Pharmacy
Pharmacy: _____ NPI: _____ Fax #: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Adults with classical Hodgkin lymphoma (HL) with CD30-expressing cells after failure of:
   - autologous hematopoietic stem cell transplant (auto- HSCT), or
   - at least two prior multi-agent chemotherapy regimens in patients who are not auto-HSCT eligible
2. Adults with classical Hodgkin lymphoma at high-risk of relapse or progression as post-auto-HSCT consolidation
3. Adults with systemic anaplastic large cell lymphoma (sALCL) after failure of one multi-agent chemotherapy regimen
4. Adults with CD30-expressing mycosis fungoides who have received prior systemic therapy
5. Adults with primary cutaneous anaplastic large cell lymphoma who have received prior systemic therapy
6. Adults with untreated Stage III or IV classical Hodgkin lymphoma in combination with chemotherapy.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 12/2017
Last reviewed 11/2019

Note: Authorization for indications, dosing, or a route of administration 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 appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being used for?

☐ Classical Hodgkin lymphoma (HL) with CD30-expressing cells

1) Did the patient fail autologous hematopoietic stem cell transplant?
   ☐ Yes
   ☐ No

2) Did the patient fail two multi-agent chemotherapy regimens?
   ☐ No
   ☐ Yes. *List the regimens below.*

   Regimen 1: _____
   Regimen 2: _____

☐ Classical Hodgkin lymphoma (HL) at high-risk of relapse or progression as post-auto-HSCT consolidation

Date of auto-HSCT: _____

☐ Systemic anaplastic large cell lymphoma (sALCL)
What previous chemotherapy regimen was used for this patient?

Regimen: _____

☐ CD30-expressing mycosis fungoides
What previous chemotherapy regimen was used for this patient?

Regimen: _____

☐ Primary cutaneous anaplastic large cell lymphoma
What previous chemotherapy regimen was used for this patient?

Regimen: _____

☐ Adults with untreated Stage III or IV classical Hodgkin lymphoma in combination with chemotherapy

☐ Other – *Rationale for use:* _____

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Updated 12/2017
Last reviewed 11/2019