

Pharmacy 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.

Alecensa[®] (alectinib)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

Drug product: Alecensa 150 mg capsule

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Oral oncology partial fill program

Each fill of Alecensa is limited to a 14 day supply at any network pharmacy. Patients are responsible for applicable deductible and copayments.

Precertification Requirements

For this drug to be covered, the patient must meet the following criteria:

1. Diagnosis of anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test

Additional information

Requests for any condition not listed as covered require evidence of current medical literature that substantiates the drug's efficacy or that recognized oncology organizations generally accept the treatment for the condition.

Priority Health Precertification Documentation

1. What is the patient's diagnosis?

Anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test

Other – the patient's condition is: _____
Rationale for use: _____