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.

Aliqopa® (copanlisib)

Member

Last Name: ____________________ First Name: ____________________

ID #: ____________________ DOB: ____________ Gender: ____________

Primary Care Physician: ____________________

Requesting Physician: ____________________ Phys. Phone: ____________ Phys. Fax: ____________

Physician Address: ____

Physician NPI: ____________________ Contact Name: ____________________

Provider Signature: ____________________ Date: ____________

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Aliqopa 60 mg vial

Dose:__________ **Dose Frequency**:__________

Start date (or date of next dose): ____________________

Date of last dose (if applicable): ____________________

Date of next dose: ____________________

Place of administration:

☐ Physician's office

☐ Outpatient infusion

Facility: ____________ NPI:____________ Fax:____________

☐ Home infusion

Facility: ____________ NPI:____________ Fax:____________

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy:____________ NPI:____________ Fax:____________

ICD code(s): ____________________

Precertification Requirements

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

1. Patient must be age 18 years or older.
2. Have a diagnosis of relapsed Follicular lymphoma (FL).
3. Must have previously tried at least two prior systemic therapies for FL, including rituximab and an alkylating agent.
4. Must not have previously used another phosphatidylinositol-3-kinase inhibitor (i.e. Zydelig).

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.

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

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Relapsed Follicular lymphoma
- ☐ Other – rationale for use: ______________________________

B. What previous treatment(s) has/have the patient used? (e.g. Rituxan, bendamustine, chlorambucil, fludarabine, cyclophosphamide.)

Previous therapy: ______________________ Date: ______________
Previous therapy: ______________________ Date: ______________
Previous therapy: ______________________ Date: ______________

C. Has the patient previously used Zydelig?

- ☐ Yes
- ☐ No

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New 11/2017
Last reviewed 11/2018