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-10 Diagnosis code(s): ____________________

Precertification Requirements

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

1. 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 have previously tried Zydelig.
5. Must not have previously had disease progression on another phosphatidylinositol-3-kinase inhibitor.

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

New 11/2017

Last reviewed 11/2018

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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 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