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: _____

ICD-10 Diagnosis code(s): _____

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:_____

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.

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.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 11/2017
Last reviewed 11/2019

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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