PriorityHealth

# 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.

# Alunbrig® (brigatinib)

## 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

☐ New Request ☐ Continuation Request

Drug product: ☐ Alunbrig 30 mg tablet

**Start date** (or date of next dose): _____

**Date of last dose** (if applicable): _____

**Dosing frequency:** _____

## Oral oncology partial fill program

Each fill of Alunbrig is limited to a 14 day supply. 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)
2. Had disease progression or was intolerant to crizotinib (Xalkori)
3. Must have tried alectinib (Alecensa)

## Priority Health Precertification Documentation

**A. What condition is this drug being requested for?**

☐ ALK-positive, metastatic non-small cell lung cancer

☐ *Other – the patient's condition is:* _____

*Rationale for use:* _____



**All fields must be complete and legible for review. Your office will receive a response via fax.** No changes made since 12/2018

Last reviewed 01/2020

**B. Has the patient had disease progression or intolerance to Xalkori?**

☐ Yes; date and duration of trial:_____

☐ No; rationale for use:_____

**C. Has the patient had disease progression or intolerance to Alecensa?**

☐ Yes; date and duration of trial:_____

☐ No; rationale for use:_____

## 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.



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