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.

Beleodaq® (belinostat)

Member

Last Name: ______________________ First Name: ______________________

ID #: ______________________ DOB: ______________ Gender: ______________

Primary Care Physician: ______________________

Requesting Physician: ______________________ Phys. Phone: ______________ Phys. Fax: ______________

Provider Address: ____

Physician NPI: ______________________ Contact Name: ______________________

Physician Signature: ______________________ Date: ______________

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Beleodaq 500mg vial

Start date (or date of next dose): ______________

Date of last dose (if applicable): ______________

Date of next dose: ______________

Dose: ______________

Dosing frequency: ______________

Height: ______ **Weight**: _______

Place of administration:

☐ Physician's office

☐ Outpatient infusion center

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. Diagnosis of peripheral T cell lymphoma
2. Relapse or refractory after at least one first line chemotherapy regimen (e.g. CHOP or variation thereof)

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

No changes made since 09/2014
Last reviewed 09/2018

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.

Priority Health Precertification Documentation

A. Is this drug being requested to treat peripheral T cell lymphoma (PTCL)?

- ☐ Yes. The date of the patient's diagnosis was: ____________________
- ☐ No. The patient's condition is: ____

B. Has the patient's condition relapsed or is treatment with Beleodaq being given refractory to at least one other chemotherapy treatment (e.g. CHOP-cyclophosphamide, doxorubicin, vincristine, prednisone, or variation of CHOP)?

- ☐ Yes. The previous regimen(s) and dates of treatment are:

____
____
____
____

- ☐ No

Additional Information

The recommended dose is 1,000 mg/m^2 given over 30 minutes by intravenous infusion once daily on Days 1 to 5 of a 21-day cycle. Cycles can be repeated until disease progression or unacceptable toxicity.

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Last reviewed 09/2018