Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Beleodaq® (belinostat)

Reset Form

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____

Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____
Physician 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**: _____ **Body Surface Area**: _____

ICD-10 Diagnosis code(s): _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Diagnosis of peripheral T cell lymphoma
2. Relapse or refractory after at least one first line chemotherapy regimen (e.g. CHOP, CHOEP, or dose-adjusted EPOCH)

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

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 09/2017

Priority Health Precertification Documentation

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

☐ Yes
☐ 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

Priority Health Medicare plans

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

WPS-Medicare LCD L28576 (ICD-9) or L35053 (ICD-10)

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Beleodaq likely be the most effective option for this patient?

☐ No
☐ Yes, because: _____

_____

_____

If the patient is currently using Beleodaq, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ No
☐ Yes, because: _____

_____

_____

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