Medicare Part B 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: ☐ **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.

Blincyto® (blinatumomab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Prov. Phone: _____ Prov. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Physician Signature: _____ Date: _____

Product and Billing Information

☐ New request ☐ Continuation request

Drug product: ☐ Blincyto 35 mcg/vial

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose:_____ **Dose Frequency**:_____

Place of administration:

☐ Physician's office

☐ Outpatient infusion

Facility: _____ NPI:_____ Fax:_____

☐ Home infusion

Agency: _____ NPI:_____ Fax:_____

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 05/2018

Last reviewed 05/2019

Precertification Requirements

Patient must meet all of the criteria outlined in WPS-Medicare LCD L35053:

1. For the treatment of relapsed or refractory B cell precursor acute lymphoblastic leukemia (ALL)
2. For the treatment of B cell precursor acute lymphoblastic leukemia (ALL) in first or second remission with minimal residual disease (MRD) greater than or equal to 0.1%

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. What is the patient's condition this drug is prescribed for?

- ☐ Philadelphia chromosome-negative relapsed or refractory B cell precursor ALL
- ☐ Philadelphia chromosome–positive relapsed or refractory B cell precursor acute lymphoblastic leukemia (ALL)
- ☐ *Other – the patient's condition is:* _____

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Last reviewed 05/2019