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.

Bosulif® (bosutinib)

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: ☐ Bosulif oral tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

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.

Before this drug is covered, the patient must meet all of the following requirements:

1. Must have one of the following diagnoses or another medically-accepted indication* and meet any corresponding requirements:
    a. Philadelphia chromosome-positive chronic myeloid leukemia (CML) chronic, accelerated, or blast phase
        - Must first try imatinib
    b. Philadelphia chromosome-positive chronic myelogenous leukemia (CML), newly diagnosed, chronic phase

2. BCR-ABL1 Gene Arrangement, Quantitative PCR will be completed at:
    a. baseline,
    b. then every 3 months to assess response to therapy until complete cytogenetic response,
    c. then every 3 months for 3 years, AND
    d. then every 3-6 months thereafter

3. If loss of response to Bosulif occurs, a BCR-ABL kinase domain mutation analysis must be done before changing therapy

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2019

Last reviewed 01/2019

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 for a drug or biologic used in an anti-cancer chemotherapeutic regimen is a use 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.)
- supported by one of the following references (known as compendia): National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Micromedex DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology, or Lexi-Drugs
- — *or* — supported in peer-reviewed medical literature appearing in regular editions of approved publications

Additional information

Note: When criteria are met, duration of approval will be 1 year. Bosulif 100 mg tablet has a quantity limit of 120 tablets per 30 days. Bosulif 400 mg and 500 mg tablets have a quantity limit of 30 tablets per 30 days.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Philadelphia chromosome-positive CML, chronic, accelerated, blast phase, resistant/intolerant to prior therapy

Has the patient tried imatinib?

☐ Yes

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

☐ Philadelphia chromosome-positive CML, newly diagnosed, chronic phase

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

Rationale for Other use: _____

B. Will BCR-ABL1 Gene Arrangement, Quantitative PCR be completed at the following times?

☐ Yes

☐ Baseline,

☐ Every 3 months to assess response to therapy until complete cytogenetic response,

☐ Every 3 months for 3 years, AND

☐ Every 3-6 months thereafter

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

C. If loss of response to Bosulif occurs, will a BCR-ABL kinase domain mutation analysis be done before changing therapy?

☐ Yes

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

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Last reviewed 01/2019

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

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 Bosulif likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using Bosulif, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

_____

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Last reviewed 01/2019