# 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.

# Caprelsa® (vandetanib)

## 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: ☐ Caprelsa 100 mg tablet ☐ Caprelsa 300 mg 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.

1. Patient must have one of the following conditions:
    a. Symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease
    b. Progressive non-small cell lung cancer after failure of first or second line chemotherapy
2. Baseline ECG obtained to monitor QT at baseline, then 2-4 weeks and 8-12 weeks after starting Caprelsa
3. Patient must not have uncorrected hypocalcemia, hypokalemia, hypomagnesemia, or congenital long QT syndrome or a history of Torsades de pointes

## 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 07/2014
Last reviewed 07/2019

## Priority Health Precertification Documentation

**A. What is the patient's diagnosis?**

- ☐ Medullary thyroid cancer
  - Which of the following describes the patient's disease progression?
    - ☐ Unresectable locally advanced or metastatic disease
    - ☐ Indolent, asymptomatic, or slowly progressive disease
- ☐ Progressive non-small cell lung cancer
  - *Please list previous chemotherapy used:*_____
- ☐ *Other – the patient's condition is:* _____

**B. Has (or will) a baseline ECG be obtained to monitor QT at baseline, at 2-4 weeks, 8-12 weeks, then every 3 months after starting Caprelsa?**

☐ Yes ☐ No

**C. Which, if any, of the following apply to this patient?**

- ☐ Uncorrected hypocalcemia
- ☐ Uncorrected hypokalemia
- ☐ Uncorrected hypomagnesemia
- ☐ Congenital long QT syndrome
- ☐ History of Torsaes de pointes
- ☐ None of the above applies to this patient

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

**If the patient is currently using Caprelsa, 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 07/2019