

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.

Erwinaze[®] (asparaginase erwinia chrysanthemi)

Member

Last Name: _____

ID #: _____

Primary Care Physician: _____

Requesting Physician: _____

Physician Address: _____

Physician NPI: _____

Physician Signature: _____

First Name: _____

DOB: _____ Gender: _____

Prov. Phone: _____ Prov. Fax: _____

Contact Name: _____

Date: _____

Product and Billing Information

New Request Continuation Request

Drug product: Erwinaze 10,000 unit powder for inj.

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

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 (please provide supporting documentation):

1. Diagnosis of acute lymphoid leukemia
2. Must have a documented trial with Elspar or Oncaspar

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. Which of the following drugs has the patient tried?

Elspar

Oncaspar

Other – rationale for use: _____