PriorityHealth

Pharmacy Prior Authorization Form

For Prior Authorization, please fax 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.

Gilotrif® (afatinib)

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

☐ Gilotrif 20 mg tablet
☐ Gilotrif 30 mg tablet
☐ Gilotrif 40 mg tablet

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for a 30-day supply of Gilotrif is $8,155. The annual cost of treatment with this drug is more than $97,000.

Precertification Requirements

Before this drug is covered, patient must have one of the following conditions and meet additional criteria for that condition:

1. Diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors have non-resistant epidermal growth factor receptor (EGFR) mutations, as confirmed by an FDA-approved test
2. Diagnosis of metastatic, squamous NSCLC with progression after treatment with platinum-based chemotherapy
3. Diagnosis of advanced squamous cell carcinoma of the head and neck after failure of platinum-based chemotherapy

Additional information

Dosing is limited to one tablet daily.

Requests for any condition not listed as covered require evidence of current medical literature that substantiates the drug's efficacy or that recognized oncology organizations generally accept the treatment for the condition.

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 11/2017
Last reviewed 03/2018

Priority Health Precertification Documentation

Covered condition **(Place an "X" in the box for the condition this drug is being requested for.)**	**Requirements that must be met before the drug is covered** **(Place an "X" in the appropriate box to indicate the patient has met the required criteria.)**
☐ Advanced squamous cell carcinoma of the head/neck	Has the patient previously been treated with platinum-based chemotherapy? ☐ Yes ☐ No
☐ Metastatic, squamous NSCLC	Has the patient previously been treated with platinum-based chemotherapy? ☐ Yes ☐ No
☐ Metastatic NSCLC	Which of the following mutations have been confirmed by an FDA-approved test? ☐ exon 19 deletions ☐ exon 21 (L858R) substitution mutations ☐ Other: _____

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