

# 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.

## Gilotrif<sup>®</sup> (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: \_\_\_\_\_

### Drug Information

New request  Continuation request

Drug product:  Gilotrif 20 mg tablet **Start date** (or date of next dose): \_\_\_\_\_  
 Gilotrif 30 mg tablet **Date of last dose** (if applicable): \_\_\_\_\_  
 Gilotrif 40 mg tablet **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.

**For this drug to be covered, the patient must meet the following criteria:**

1. Must be used for a medically-accepted indication\*

### Additional information

**Note:** When criteria are met, duration of approval will be 1 year. Gilotrif is limited to a quantity of 30 tablets per 30 days.

### 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

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**Priority Health Precertification Documentation**

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

- Metastatic non-small cell lung cancer
- Metastatic squamous non-small cell lung cancer
- Squamous cell carcinoma of the head and neck
- Other – the patient's condition is: \_\_\_\_\_

**Rationale for Other use:** \_\_\_\_\_

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**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 Gilotrif likely be the most effective option for this patient?**

- No
- Yes, because: \_\_\_\_\_

**If the patient is currently using Gilotrif, would changing the patient's current regimen likely result in adverse effects for the patient?**

- No
- Yes, because: \_\_\_\_\_