

# 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.

## Hexalen<sup>®</sup> (altretamine)

### 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:                       Hexalen 50 mg capsules      **Start date** (or date of next dose): \_\_\_\_\_  
**Date of last dose** (if applicable): \_\_\_\_\_  
**Dosing frequency:** \_\_\_\_\_

### Drug cost information

The wholesale acquisition cost for Hexalen is \$15.90 for each capsule. The cost of treatment with this drug will vary depending on the patient's circumstances, but may be more than \$51,000 each year.

### Oral oncology partial fill program

Each fill of Hexalen is limited to a 14 day supply. Patients are responsible for applicable deductible and copayments.

### Precertification Requirements

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

1. Must be treating recurrent or persistent ovarian cancer
2. Must have failed first-line therapy with a cisplatin- OR alkylating agent-based chemotherapy

### Priority Health Precertification Documentation

#### A. What condition is this drug being requested for?

- Recurrent or persistent ovarian cancer  
 Other – the patient's condition is: \_\_\_\_\_  
Rationale for use: \_\_\_\_\_

**B. Has the member previously tried either of the following?**

	<b>Dates</b>	<b>Outcome</b>
<input type="checkbox"/> Cisplatin-based chemotherapy	_____	_____
<input type="checkbox"/> Alkylating agent-based	_____	_____
<input type="checkbox"/> Not all requirements are met – Below is rationale for use: _____		