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.

Iclusig® (ponatinib)

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: ☐ Iclusig 15 mg tablet ☐ Iclusig 45 mg tablet

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

Each fill of Iclusig is limited to a 14-day partial fill at any network pharmacy.

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.)

What condition is this drug being requested for?

☐ Chronic myeloid leukemia
☐ Philadelphia chromosome positive acute lymphoblastic leukemia
☐ *Other – the patient's condition is:* _____

For patients with CML, will the required monitoring (listed below) be completed? ☐ Yes ☐ No

A. BCR-ALB1 Gene Arrangement, Quantitative PCR will be completed at
   1. baseline,
   2. then every 3 months to assess response to therapy until complete cytogenetic response,
   3. then every 3 months for 3 years,
   4. then every 3-6 months thereafter.
B. Loss of response to previous TKI: BCR-ABL kinase domain mutation analysis before change in therapy.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 12/2015
Last reviewed 07/2018

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 Iclusig likely be the most effective option for this patient?
☐ No
☐ Yes, because:_____

_____

_____

If the patient is currently using Iclusig, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ No
☐ Yes, because:_____

_____

_____

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Last reviewed 07/2018