Pharmacy 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.

Iressa® (gefitinib)

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: ☐ Iressa 250 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Oral oncology partial fill program

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

Drug cost information

The wholesale acquisition cost for each tablet is $253.26. The annual cost of treatment with this drug is $90,000.

Precertification Requirements

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

1. Must be using for diagnosis of metastatic non-small cell lung cancer (NSCLC) and have documented expression of the epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by a FDA-approved test.

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.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 09/2018
Last reviewed 09/2018

Priority Health Precertification Documentation

1. What conditions is this drug being requested for?

- ☐ Metastatic NSCLC
- ☐ Other, rationale: _____

2. Does patient have documented expression of EGFR exon 19 deletions or exon 21 (L858R) substitution?

- ☐ Yes (Please fax documentation, as this is required for approval)
- ☐ No, rationale: _____

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