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.

Istodax® (romidepsin)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Prov. Phone: _____ Prov. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Physician Signature: _____ Date: _____

Product Information

☐ New Request ☐ Continuation Request

Drug product:
- ☐ Istodax intravenous kit
- ☐ Romidepsin intravenous kit

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose:_____ **Dose Frequency**:_____

Place of administration:
- ☐ Physician's office
- ☐ Outpatient infusion
  - Facility: _____ NPI:_____ Fax:_____
- ☐ Home infusion
  - Facility: _____ NPI:_____ Fax:_____

Billing:
- ☐ Physician to buy and bill
- ☐ Facility to buy and bill
- ☐ Specialty Pharmacy
  - Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

Drug cost information

The wholesale acquisition cost for each Istodax® kit is $3,198. The annual cost of treatment with this drug will vary depending on the patient's weight.

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

New 12/2017
Last reviewed 03/2019

Precertification Requirements

Before this drug is covered, documentation must be submitted to support that the patient meets all of the following requirements:

1. For diagnosis of Cutaneous T-cell Lymphoma (CTCL)
    a. Must have previously received at least one prior systemic therapy

2. For diagnosis of Peripheral T-cell Lymphoma (PTCL)
    a. Must have received at least one prior therapy

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.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ *Cutaneous T-cell Lymphoma*
☐ *Peripheral T-cell Lymphoma*
☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. What therapy(s) has the patient tried?

Drug	Dose	Dates	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ None; rationale for use: _____

_____

_____

Additional information

Note: If approved, the amount of Istodax® covered will be limited to the FDA-approved dosing.

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

New 12/2017
Last reviewed 03/2019