PriorityHealth

Medical 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.

Lartruvo™ (olaratumab)

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 and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Lartruvo 500 mg/50 mL injection

Start date (or date of next dose): ______________

Date of last dose (if applicable): ______________

Dosing frequency: ______________

Patient weight: ______________

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): ______________

Precertification Requirements

Patient must meet all of the following criteria:

1) Diagnosis of locally advanced or metastatic soft tissue sarcoma not amenable to curative treatment with radiotherapy or surgery
2) The patient has a histologic type of sarcoma for which an anthracycline regimen is appropriate
3) Must not have Kaposi's sarcoma or untreated central nervous system metastases

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

New 01/2017
Last reviewed 03/2019

4) Must not have a left ventricular ejection fraction < 50%, unstable angina pectoris, angioplasty, cardiac stenting, or a myocardial infarction with the previous 6 months
5) Lartruvo must be used in combination with doxorubicin for 8 cycles
6) Age 18 years or older
7) Eastern Cooperative Oncology Group (ECOG) performance status of 0-2

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 is the patient's diagnosis?

- ☐ Locally soft tissue sarcoma not amenable to curative treatment with radiotherapy or surgery
  - ☐ Sarcoma has a histologic type for which an anthracycline regimen is appropriate
- ☐ Other – rationale for use: ____________________

B. Please describe the histologic subtype:

____

C. Does the patient have Kaposi's sarcoma or untreated central nervous system metastases?

- ☐ Yes
- ☐ No

D. Has the patient experienced any of the following in the past 6 months?

- ☐ Left ventricular ejection fraction < 50%
- ☐ Unstable angina pectoris
- ☐ Angioplasty
- ☐ Cardiac stenting
- ☐ Myocardial infarction
- ☐ None of the above

E. Will Lartruvo be used in combination with doxorubicin for the first 8 cycles of therapy?

- ☐ Yes
- ☐ No

F. Eastern Cooperative Oncology Group (ECOG) performance status:

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ Other – rationale for use: ____________________