PriorityHealth

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.

Lenvima® (lenvatinib)

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:

☐ Lenvima 4 mg ☐ Lenvima 14 mg

☐ Lenvima 8 mg ☐ Lenvima 18 mg

☐ Lenvima 10 mg ☐ Lenvima 20 mg

☐ Lenvima 12 mg ☐ Lenvima 24 mg

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for Lenvima is $416.67 each day. The annual cost of treatment with this drug is $150,000.

Precertification Requirements

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

1. Must be used for the treatment of differentiated, locally recurrent or metastatic, progressive, refractory to radioactive iodine thyroid cancer.
2. Must be used for the treatment of advanced renal cell carcinoma, in combination with everolimus, after 1 prior anti-angiogenic therapy.
3. Must be used for the treatment of unresectable liver carcinoma (first-line therapy).
4. Must be used in combination with pembrolizumab (Keytruda),for the treatment of advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR), with progression following prior systemic therapy. Patient must not be a candidate for curative surgery or radiation.

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. No changes made since 01/2020

Last reviewed 01/2020

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Thyroid cancer: Metastatic or locally advanced, progressive, differentiated, and refractory to radioactive iodine
- ☐ Renal cell carcinoma: Advanced, in combination with everolimus, after 1 prior anti-angiogenic therapy
- ☐ Liver carcinoma: Unresectable, first-line therapy
- ☐ Advanced endometrial carcinoma: Not MSI-H or dMMR, in combination with pembrolizumab, after disease progression following prior systemic therapy, not candidate for curative surgery or radiation
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Please provide previous anti-angiogenic therapies:

_____ Dates: _____

_____ Dates: _____

Additional information

Requests for any condition not listed as covered require evidence of current medical literature that substantiates the drug's efficacy or that recognized oncology organizations generally accept the treatment for the condition.

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Last reviewed 01/2020