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.

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 oral capsule

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.

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically-accepted indication*

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 for a drug or biologic used in an anti-cancer chemotherapeutic regimen is a use 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.)
- supported by one of the following references (known as compendia): National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Micromedex DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology, or Lexi-Drugs
- — *or* — supported in peer-reviewed medical literature appearing in regular editions of approved publications

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2019

Last reviewed 01/2019

Additional information

Note: When approved, coverage duration is 1 year. Lenvima has a quantity limit depending on the strength:

Lenvima 4 mg capsule	QL (30 capsules per 30 days)
Lenvima 8 mg capsule	QL (60 capsules per 30 days)
Lenvima 10 mg capsule	QL (30 capsules per 30 days)
Lenvima 12 mg capsule	QL (90 capsules per 30 days)
Lenvima 14 mg capsule	QL (60 capsules per 30 days)
Lenvima 18 mg capsule	QL (90 capsules per 30 days)
Lenvima 20 mg capsule	QL (60 capsules per 30 days)
Lenvima 24 mg capsule	QL (90 capsules per 30 days)

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Differentiated thyroid cancer, advanced, progressive and iodine-refractory
- ☐ Renal Cell Carcinoma (RCC), advanced
  - **1. Will the patient use Lenvima in combination with everolimus?**
    - ☐ Yes
    - ☐ No. Are you requesting an exception to the criteria?
      - ☐ Yes. ***Rationale for exception***: _____
      - ☐ No
  - **2. Has the patient tried a prior anti-angiogenic therapy?**
    - ☐ Yes
      - ☐ Sutent ☐ Cyramza
      - ☐ Inlyta ☐ Stivarga
      - ☐ Avastin ☐ Nexavar
      - ☐ Votrient ☐ Caprelsa
      - ☐ Other: _____
    - ☐ No. Are you requesting an exception to the criteria?
      - ☐ Yes. *Rationale for exception*: _____
      - ☐ No
- ☐ Hepatocellular carcinoma (HCC), unresectable
  1. Is Lenvima being used as first-line therapy?
     - ☐ Yes
     - ☐ No. Are you requesting an exception to the criteria?
       - ☐ Yes. *Rationale for exception*: _____
       - ☐ No
- ☐ *Other – the patient's condition is:* _____

Rationale for Other use: _____

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Priority Health Medicare Exception Request *(exceptions to the above criteria)*

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

_____

_____

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

_____

_____

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Last reviewed 01/2019