PriorityHealth

Medical Prior Authorization Form

For Prior Authorization, please fax 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.

Marqibo® (vincristine – liposome)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Marqibo kit

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

ICD-10 Diagnosis code(s): _____

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: _____

Drug cost information

The wholesale acquisition cost for a 28-day supply of Marqibo is $45,449.24. The annual cost of treatment with this drug is more than $590,800.00.

Precertification Requirements

Patient must have one of the following diagnoses (and meet any additional criteria for that condition):

1. Diagnosis of Philadelphia chromosome-negative acute lymphocytic leukemia (ALL)
2. Patient's condition has relapsed two or more times,
   –*or*– patient has tried two other drugs and continues to have disease progression

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

Updated 11/2017
Last reviewed 11/2019

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

- ☐ Philadelphia chromosome-negative acute lymphoblastic leukemia (ALL)
- ☐ *Other – the patient's condition is:* _____
  Rationale for use: _____

B. Has the patient experienced two or more relapses of his or her condition?

- ☐ Yes
- ☐ No

C. What prior therapies has the patient tried?

Drug: _____	Dates used: _____
Drug: _____	Dates used: _____
Drug: _____	Dates used: _____
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Drug: _____	Dates used: _____

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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Updated 11/2017
Last reviewed 11/2019