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: ______________

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 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 11/2018

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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: ______________________
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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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