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.

Nerlynx™ (neratinib)

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: _____

Drug information

☐ New request ☐ Continuation request

Drug product: ☐ Nerlynx 40 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

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:

- Diagnosis of early stage HER2-positive breast cancer
  - Must be used as extended adjuvant treatment following treatment with adjuvant Herceptin (trastuzumab)-based therapy within the past 24 months
  - Patient must be 18 years of age or older
  - Must have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1.

Dosage Limit

When criteria are met, approval will be given for a total of 12 months. Nerlynx will be limited to #180 tablets every 30 days (240 mg daily).

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.)

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

Updated 09/2018
Last reviewed 09/2018

- 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

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?
- ☐ HER2-positive breast cancer
- ☐ *Other – the patient's condition is:* _____

B. Is this early stage breast cancer?
- ☐ Yes.
- ☐ No. *Rationale for use:* _____

C. Is this for extended adjuvant treatment following Herceptin (trastuzumab) therapy in the past 24 months?
- ☐ Yes. Dates of Herceptin therapy*:* _____
- ☐ No. *Rationale for use:* _____

D. What is the patient's ECOG performance status?
- ☐ 0: Fully active, able to carry on all pre-disease performance without restriction
- ☐ 1: Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature (e.g. light house work, office work)
- ☐ 2: Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours
- ☐ 3: Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
- ☐ 4: Completely disabled; cannot carry on any self-care; totally confined to bed or chair

Priority Health Medicare exception request

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

_____

_____

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

_____

_____

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