

Pharmacy 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.

Ninlaro[®] (ixazomib)

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 and Billing Information

New Request Continuation Request

Drug product: Ninlaro 2.3 mg capsule

Start date (or date of next dose): _____

Ninlaro 3 mg capsule

Date of last dose (if applicable): _____

Ninlaro 4 mg capsule

Dosage & dosing frequency: _____

Drug cost information

The wholesale acquisition cost for each 4 mg dose of Ninlaro is \$2,890. The annual cost of maintenance treatment with this drug is more than \$112,710.

Precertification Requirements

Ninlaro is covered when used for treatment of:

- Multiple myeloma, in patients who have received at least one prior therapy, in combination with Revlimid and dexamethasone.

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.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

Multiple myeloma

Other, rationale: _____

B. Please list prior therapy: _____

C. Will Ninlaro be used in combination with Revlimid and dexamethasone?

Yes

No, rationale: _____