

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206 This form applies to: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review) This request is: 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. **Oncology Drug Request** Member DOB: Gender: Primary Care Physician: Requesting Provider: Prov. Phone: _____ Prov. Fax: _____ Requesting Provider Specialty: Provider Address: Provider NPI: Contact Name: Provider Signature: **Product Information** ☐ New Request ☐ Continuation Request Drug product: Start date (or date of next dose): Date of last dose (if applicable): Dosing frequency: Oral oncology partial fill program notice Select oncology mediations are limited to a 14-day supply at any network pharmacy. Patients are responsible for applicable deductible and copayments. **Precertification Requirements**

Patient must meet all of the following criteria (supporting documentation is required):

- 1. Must have a Food and Drug Administration (FDA) approved indication for use or use must be consistent with National Comprehensive Cancer Network guidelines category 1 or 2A recommendations for cancer type, cancer stage, line of therapy and performance status. Consideration for coverage which do not meet the above criteria require submission from two peer-reviewed medical journal articles.
- 2. Coverage for National Comprehensive Cancer Network guidelines category 2B recommendations will be considered after failure of category 1 or 2A recommendations or when higher recommendations are not indicated.
- 3. Prescribed by an oncologist, hematologist, or another board-certified prescriber with qualifications to treat specified cancer type.
- 4. Appropriate genetic testing results to support use based on FDA approved package labeling and NCCN
- 5. Must have an Eastern Cooperative Oncology Group (ECOG) score between 0 and 2.
- 6. Additional criteria as stated on drug-specific prior authorization forms on Priority Health's website.

When the above criteria is met, initial approval for coverage of the requested medication will be for no more than 12 months.



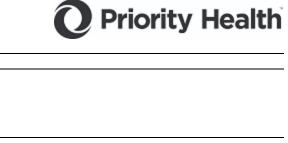
For continuation, patient must meet the following requirements:

- 1. Current chart notes must be provided detailing response and compliance to therapy.
- 2. Coverage may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR disease progression has occurred after initiation of drug therapy.

When the above continuation criteria is met, approval for coverage of the requested medication will be for no more than 12 months.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation		
. Wh	nat condition is this drug being requested for?	
. Is u	use consistent with one or more of the following? FDA approved indication NCCN guideline category 1 or 2A recommendation NCCN guideline category 2B Off-label (two peer-reviewed medical journal articles must be sub	omitted to support use)
	nat previous treatment has the patient used? . chemotherapy, immunotherapy, targeted oral therapy, stem cell transplar	nt)
	Previous therapy: Previous therapy: Previous therapy: Previous therapy: Previous therapy: Previous therapy:	Date: Date: Date: Date: Date: Date:
. Wh	nat is the patient's Eastern Cooperative Oncology Group (ECOG) perf ☐ 0, Fully active, able to carry on activity without restriction ☐ 1, Restricted in heavy activity, but able to carry out work of light r ☐ 2, Ambulatory and capable of self-care, but unable to carry out an ☐ ≥ 3, capable of limited self-care or completely disabled ☐ Other: (please provide other measure performance status.	nature, e.g. house or office work ny work activities
Hav	ve chart notes and lab records been submitted with this request? Yes No	
eque	est to continue a previously authorized approval	
. Has	s the patient been compliant with therapy? Yes No; rationale for continued use:	
2. Has	s the patient had a response to therapy?	



	☐ No; rationale for continued use:
3.	Has the patient's condition progressed since starting therapy? ☐ Yes
	☐ No; rationale for continued use:
4.	Documentation of clinical outcomes must be submitted to Priority Health