

Medical prior authorization form

Fax completed form 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.

Onivyde[®] (irinotecan liposomal)

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: Onivyde 4.3 mg/mL injection **Dose:** _____ **Dose Frequency:** _____

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose: _____

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): _____

Precertification Requirements

Before this drug is covered, the patient must use the drug for treatment of adenocarcinoma of pancreas, metastatic progressive disease following gemcitabine-based therapy; in combination with fluorouracil and leucovorin.

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

A. What condition is this drug being requested for?

- Adenocarcinoma of pancreas, metastatic progressive disease
- Other – rationale for use: _____

B. Which of the following drugs has the patient tried?

- Gemcitabine
- Other: _____