Medicare Part B 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: ☐ **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)

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: ☐ Onivyde 4.3 mg/mL injection

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose:_____ **Dose 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): _____

Precertification Requirements

Patient must meet all of the following:

1. Onivyde must be used for the treatment of metastatic adenocarcinoma of the pancreas after disease progression on gemcitabine-based therapy and used in combination with fluorouracil and leucovorin.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 12/2018

Last reviewed 01/2019

Priority Health Precertification Documentation

A. What is the condition this drug is prescribed for?

- ☐ Metastatic adenocarcinoma of the pancreas
- ☐ *Other – the patient's condition is:* _____

B. Has the patient experienced disease progression following gemcitabine-based therapy?

☐ Yes ☐ No

C. Will Onivyde be used in combination with fluorouracil and leucovorin?

☐ Yes ☐ No

National and Local Coverage Determination Criteria for Medicare Part B (Medical) drugs

Note: Priority Health Medicare applies CMS national coverage determination (NCD) and local coverage determination (LCD) criteria for Part B (medical) drugs. If no NCD or LCD criteria are available for the state in which the member is receiving the services, the medication must be used for a medically-accepted indication as defined in the Medicare Benefit Policy Manual Chapter 15 § 50.

WPS-Medicare LCD: Chemotherapy Drugs and their Adjuncts (L37205)

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