Pharmacy 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**

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.

Rubraca® (rucaparib)

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 Information

☐ New request ☐ Continuation request

Drug product: ☐ Rubraca oral tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

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.

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be used for a medically-accepted indication*
2. Must have tried at least two other chemotherapies

Additional information

Note: If approved, duration of approval will be for 1 year. Rubraca is limited to a quantity of 120 tablets per 30 days.

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.)
- 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

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

Updated 01/2019
Last reviewed 05/2019

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Ovarian cancer
- ☐ Fallopian tube cancer
- ☐ Primary peritoneal cancer
- ☐ *Other – the patient's condition is:* _____
  - ***Rationale for Other use***: _____

B. Does the patient have deleterious germline or somatic BRCA mutated disease as confirmed by the FDA-approved companion test?

- ☐ Yes
- ☐ No

C. Does the patient have recurrent disease after complete or partial response to platinum-based chemotherapy?

- ☐ Yes
- ☐ No

D. Has the patient used at least 2 other chemotherapies?

- ☐ Yes
  - Drug/Drug regimen: _____
  - Drug/Drug regimen: _____
- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

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 Rubraca likely be the most effective option for this patient?

- ☐ No
- ☐ Yes, because: _____

_____

_____

If the patient is currently using Rubraca, would changing the patient's current regimen likely result in adverse effects for the patient?

- ☐ No
- ☐ Yes, because: _____

_____

_____

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