PriorityHealth

Pharmacy 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.

Sylatron® (peginterferon alfa-2b)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Prov. Phone: _____ Prov. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Physician Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
- ☐ Sylatron 200 mcg injection
- ☐ Sylatron 300 mcg injection
- ☐ Sylatron 600 mcg injection

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Place of administration:
- ☐ Self-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 meet all of the following criteria for initial 8-week authorization:

1. Diagnosis of stage 3 malignant melanoma with positive microscopic or gross nodular involvement
2. Started within 84 days after the cutaneous lesion is removed with documentation of adequate surgical margins and complete regional lymphadenectomy
3. Patient must not have: autoimmune hepatitis, hepatic decompensation, or neuropsychiatric disorder

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 07/2011

Last reviewed 07/2018

For each 6-month continuation, patient must have met the following requirements:

1. Patient did not experience: persistent or worsening severe neuropsychiatric disorder, grade 4 non-hematologic toxicity, or new or worsening retinopathy
2. The dose must be at least 1 mcg/kg/week, but not more than 3 mcg/kg/week
3. The patient is compliant in taking the medication as scheduled
4. The patient tolerated the medication
5. The patient did not experience any severe adverse reactions while taking the medication
6. The patient has responded to treatment, as determined by the prescribing physician

New request
Priority Health Precertification Documentation

A. What is the patient's diagnosis?

- ☐ Malignant melanoma with positive microscopic or gross nodal involvement
- ☐ *Other:* _____

Rationale for use: _____

B. Does the patient have histologically documented stage 3 melanoma?

- ☐ Yes
- ☐ No – rationale for use: _____

C. Was the primary cutaneous lesion removed with adequate surgical margins and complete lymphadenectomy?

- ☐ Yes, the date of surgery was: _____.
- ☐ No – rationale for use: _____

D. Which of the following conditions does the patient have?

- ☐ Autoimmune hepatitis
- ☐ Hepatic decompensation (Child-Pugh score of more than 6 (class B or C))
- ☐ None of the above

Continuation
Priority Health Precertification Documentation

A. After starting Sylatron, did the patient experience persistent or worsening severe neuropsychiatric disorders?

- ☐ No
- ☐ Yes – rationale for use: _____

B. Is the patient experiencing grade 4 non-hematologic toxicity because of Sylatron?

- ☐ No
- ☐ Yes – rationale for use: _____

C. Select which of the following apply (all must be met for continuation of therapy):

- ☐ The patient is compliant in taking the medication as scheduled
- ☐ The patient tolerated the medication
- ☐ The patient did not experience any severe adverse reactions while taking the medication
- ☐ The patient has responded to treatment, as determined by the prescribing physician

Additional information

Note: The initial authorization for Sylatron is limited to 8 doses (1 injection every week for 8 weeks) to allow for 6 mcg/kg/week dosing followed by 3 mcg/kg/week dosing thereafter with recertification required every 6 months. Sylatron is covered under the pharmacy benefit when the patient is self-injecting and the medical benefit if a healthcare provider is administering the injection.

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.

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