Priority Health Medicare 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**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Sylatron® (peginterferon alfa-2b)

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:
☐ 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: _____

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.

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

Continued authorized of Sylatron is required every 6 months.

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 is a use of the drug 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.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 07/2013
Last reviewed 07/2018

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

☐ Malignant melanoma with positive microscopic or gross nodal involvement
☐ *Other – the patient's condition is:* _____

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

☐ Yes ☐ No

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

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

D. Does the patient have: autoimmune hepatitis? ☐ Yes ☐ No
hepatic decompensation? ☐ Yes ☐ No

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.

Priority Health Medicare exception request

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 Sylatron likely be the most effective option for this patient?

☐ No
☐ Yes, because: _____

_____

_____

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

☐ No
☐ Yes, because: _____

_____

_____

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Last reviewed 07/2018