PriorityHealth

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.

Sylvant® (siltuximab)

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: ☒ Sylvant

Dose:_____ **Dose Frequency**:_____
Start date: _____
Date of last dose: _____
Date of next dose: _____
Height: _____ **Weight**: _____ **Body Surface Area**:_____

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 criteria:

1. Diagnosis of multicentric Castleman disease (MCD)
2. Must be HIV negative
3. Must be human herpesvirus (HHV) negative

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.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2018
Last reviewed 01/2021

Priority Health Precertification Documentation

A. Is this drug being used to treat multicentric Castleman's disease (MSD)?

- ☐ Yes
- ☐ No, the patient's condition is: _____

B. Does the patient have human immunodeficiency virus (HIV) infection?

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

C. Does the patient have human herpes virus (HHV) infection?

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

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