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.

Tagrisso® (osimertinib)

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: ☐ Tagrisso 40 mg tablet ☐ Tagrisso 80 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for Tagrisso is $487 for each tablet. The annual cost of treatment with this drug is $175,320.

Precertification Requirements

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

1. Must be used for metastatic non-small cell lung cancer (NSCLC)
    a. For epidermal growth factor receptor (EGFR) T790M mutation-positive NSCLC:
        i. Prescriber must send laboratory report confirming T790M mutation
    b. For EGFR exon 19 deletion or exon 21 L858R mutation-positive NSCLC:
        i. Prescriber must send laboratory report confirming EGFR exon 19 deletion or exon 21 L858R mutation
        ii. Must have a medical contraindication to treatment with erlotinib[1] (generic Tarceva).

[1]Erlotinib is indicated to treat non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) mutation. The NCCN give both Tagrisso and erlotinib category 1 recommendation for treatment.

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 01/2020

Last reviewed 01/2020

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Non-small cell lung cancer
- ☐ *Other – the patient's condition is:* _____
  Rationale for use: _____

A. Has the patient had a trial with erlotinib?

- ☐ Yes
- ☐ No: Medical contraindication _____

Fax a copy of the laboratory result confirming presence of the exon 19, exon 21, or T790M mutation.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2020
Last reviewed 01/2020