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.

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: _____

Drug 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: _____

Prior authorization criteria

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* not otherwise excluded from coverage under Medicare Part D.
2. For metastatic non-small cell lung cancer (NSCLC):
    a. For EGFR mutation-positive, must submit documentation of EGFR exon 19 deletion or exon 21 L858R mutation
    b. For EGFR T790M mutation-positive NSCLC, must have had disease progression on or after EGFR TKI therapy
        i. Must have laboratory confirmation of epidermal growth factor receptor (EGFR) T790M mutation, as detected by an FDA approved test

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 and the DRUGDEX Information System)

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

Updated 12/2018
Last reviewed 01/2019

PriorityHealth

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?
- ☐ Metastatic non-small cell lung cancer (NSCLC)
- ☐ *Other – the patient's condition is:* _____

B. Does the patient have EGFR mutation-positive disease?
- ☐ Yes.
- ☐ No. **Provide rationale for use:** _____

C. Does the patient have an EGFR T790M mutation as detected by an FDA approved test?
- ☐ Yes
- ☐ No. **Provide rationale for use:** _____

D. Has the patient had disease progression on or after an EGFR TKI therapy?
- ☐ Yes. Please check which medication was used previously:
  - ☐ Tarceva
  - ☐ Gilotrif
  - ☐ Iressa
- ☐ No. **Provide rationale for use:** _____

Additional information

Note: Tagrisso is limited to 30 tablets every 30 days.

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 Tagrisso likely be the most effective option for this patient?
- ☐ No
- ☐ Yes, because: _____

_____

_____

If the patient is currently using Tagrisso, would changing the patient's current regimen likely result in adverse effects for the patient?
- ☐ No
- ☐ Yes, because: _____

_____

_____

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Updated 12/2018
Last reviewed 01/2019