

# 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.

## Tibsovo<sup>®</sup> (ivosidenib)

### 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:  Tibsovo 250 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.

**For this drug to be covered, the patient must meet the following criteria:**

1. Must be used for a medically-accepted indication\*
2. Must have documentation of IDH1 mutation status as detected by an FDA-approved test
3. Patient must have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2

### 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 for a drug or biologic used in an anti-cancer chemotherapeutic regimen is a use 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.)
- supported by one of the following references (known as compendia): National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Micromedex DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology, or Lexi-Drugs
- — or — supported in peer-reviewed medical literature appearing in regular editions of approved publications

**Additional information**

**Note:** When criteria are met, coverage duration is 1 year.

**Priority Health Precertification Documentation**

**A. What condition is this drug being requested for?**

- Relapsed or refractory acute myeloid leukemia (AML)
- Other – the patient’s condition is: \_\_\_\_\_

**Rationale for Other use:** \_\_\_\_\_

**B. Does the patient have a susceptible isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA-approved test?**

- Yes
- No. **Are you requesting an exception to the criteria?**
  - Yes. **Rationale for exception:** \_\_\_\_\_
  - No

**C. Does the patient have an ECOG performance status of 0 to 2?**

- Yes. *Check which applies:*
  - 0: Fully active, able to carry on all pre-disease performance without restriction
  - 1: Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature (e.g. light house work, office work)
  - 2: Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours
  - 3: Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
  - 4: Completely disabled; cannot carry on any self-care; totally confined to bed or chair
- No. **Are you requesting an exception to the criteria?**
  - Yes. **Rationale for exception:** \_\_\_\_\_
  - No

**Priority Health Medicare Exception Request** (*exceptions to the above criteria*)

**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 Tibsovo likely be the most effective option for this patient?**

Yes  No  
 If yes, please explain why: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**If the patient is currently using Tibsovo, would changing the patient’s current regimen likely result in adverse effects for the patient?**

Yes  No  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_