PriorityHealth

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.

Torisel® (temsirolimus)

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

Drug product: ☐ Torisel 25 mg kit

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.

1. Torisel must be used for a medically accepted indication
2. If prescribed for renal cell carcinoma, three or more of the following are required:
   - Torisel is started within one year from date the patient was diagnosed
   - Karnofsky performance status is 60 or 70
   - Corrected calcium greater than 10 mg/dL
   - Lactate dehydrogenase greater than 1.5 times the upper limit of normal
   - More than one metastatic organ site
   - Hemoglobin less than lower limit of normal

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. No changes made since 11/2017

Last reviewed 11/2019

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Mantle cell lymphoma
- ☐ Renal cell carcinoma
- ☐ *Other – the patient's condition is:* _____

B. If this drug is used for renal cell carcinoma, which of the following apply to this patient?

- ☐ Treatment to start within 1 year of diagnosis
- ☐ Karnofsky performance status of 60 or 70
- ☐ Corrected calcium greater than 10 mg/dL
- ☐ Lactate dehydrogenase greater than 1.5 times the upper limit of normal
- ☐ More than one metastatic organ site
- ☐ Hemoglobin less than lower limit of normal

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 Torisel likely be the most effective option for this patient?

☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

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

☐ Yes ☐ No
If yes, please explain: _____

_____

_____

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Last reviewed 11/2019