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.

Unituxin® (dinutuximab)

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 and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☒ Unituxin 17.5 mg/5 mL

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

BSA: _____ m^2

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

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

1. Must be used for treatment of pediatric high-risk neuroblastoma
2. Must be taken with granulocyte-macrophage colony-stimulating factor (GM-CSF), interleukin-2 (IL-2), and isotretinoin
3. Must first try a first-line multi-agent, multi-modality therapy

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 07/2015
Last reviewed 07/2018

Note: Authorization for indications 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 drug's use for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ pediatric high-risk neuroblastoma
- ☐ Other – rationale for use: _____

B. What other drugs will be administered with Unituxin?

Drug: _____

Drug: _____

Drug: _____

C. What prior treatment has the patient received for pediatric high-risk neuroblastoma?

Drug: _____

Drug: _____

Drug: _____

Drug: _____

Drug: _____

Drug: _____

Additional information

When authorized, Unituxin is covered for 5 cycles. Priority Health applies the FDA-approved dosing guidelines.

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