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.

Valchlor® (mechlorethamine gel)

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: ☐ Valchlor 0.016% gel

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

The patient must meet the following criteria for Valchlor authorization:

Must have stage 1A or 1B mycosis fungoides (MF) type cutaneous T-cell lymphoma (CTCL) and must first try one of the following therapies: topical corticosteroid, topical chemotherapy, topical retinoid, imiquimod, local radiation therapy, or phototherapy.

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.

Additional information

Requests for any condition not listed as covered require evidence of current medical literature that substantiates the drug's efficacy or that recognized oncology organizations generally accept the treatment for the condition.

Priority Health Precertification Documentation

1. What condition is this drug being requested for?

☐ Stage 1A or 1B mycosis fungoides (MF) type cutaneous T-cell lymphoma (CTCL)

☐ *Other – the patient's condition is:* _____

Rationale for use: _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2014

Last reviewed 01/2019

2. Which of the following skin-directed therapies has the patient previously tried?

- ☐ Prior use of one or more of the following skin directed therapies (check which applies):
- ☐ Topical corticosteroids,
- ☐ Topical chemotherapy (e.g., BiCNU and mechlorethamine)
- ☐ Topical retinoids
- ☐ Topical imiquimod
- ☐ Local radiation therapy
- ☐ Phototherapy (ultraviolet [UV] B for patch or thin plaques; psoralen plus UVA [PUVA] for thicker plaques)

Date of previous therapy: _____

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Last reviewed 01/2019