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.

Venclexta™ (venetoclax)

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:
- ☐ Venclexta Starting Pack
- ☐ Venclexta 10 mg tablet
- ☐ Venclexta 50 mg tablet
- ☐ Venclexta 100 mg tablet

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Precertification Requirements

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. Must have chronic lymphocytic leukemia (CLL) with 17p deletion as detected by an FDA approved test.
    a. Must have received at least one prior treatment
2. Newly-diagnosed acute myeloid leukemia (AML), in combination with azacitidine or decitabine or low-dose cytarabine, in adults who are ≥60 years or who have comorbidities that preclude use of intensive induction chemotherapy.

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, the DRUGDEX Information System, and the USPDI or its successor.)

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

No changes made since 03/2019
Last reviewed 07/2019

Priority Health Precertification Documentation

1. What condition is this drug being requested for?

- ☐ Chronic lymphocytic leukemia with 17p deletion
- ☐ Newly-diagnosed acute myeloid leukemia (AML), in combination with azacitidine or decitabine or low-dose cytarabine, in adults who are ≥60 years or who have comorbidities that preclude use of intensive induction chemotherapy.
- ☐ Other – the patient's condition is: _____

2. What previous treatment has the patient used for CLL?
(e.g. chemotherapy, Rituxan, Velcade, Imbruvica)

Previous therapy: _____ Date: _____
Previous therapy: _____ Date: _____
Previous therapy: _____ Date: _____

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 Venclexta likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

If the patient is currently using Venclexta, 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 07/2019