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.

Xatmep™ (methotrexate oral solution)

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

☐ New request ☐ Continuation request

Drug product ☐ Xatmep 2.5 mg/mL oral solution

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, it must be used for one of the following indications:

1. Treatment of a pediatric patient with acute lymphoblastic leukemia (ALL) as part of a multi-phase, combination chemotherapy maintenance regimen.

2. Management of a pediatric patient with active polyarticular juvenile idiopathic arthritis (pJIA) who has had an insufficient therapeutic response to, or is intolerant of, an adequate trial of first-line therapy including full dose non-steroidal anti-inflammatory agents (NSAIDs).

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.

Updated 08/2017
Last reviewed 03/2019

PriorityHealth

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Acute lymphoblastic leukemia (ALL) as part of a multi-phase, combination chemotherapy maintenance regimen
- ☐ Active polyarticular juvenile idiopathic arthritis (pJIA)
- ☐ *Other – the patient's condition is:* _____

B. Is this a pediatric patient?

- ☐ Yes.
- ☐ No. *Rationale for use:* _____

C. For the diagnosis of pJIA, has the patient had an insufficient response to, or an intolerance of, non-steroidal anti-inflammatory agents (NSAIDs)?

- ☐ Yes. *Please list the medication(s), dose(s), date(s) of use, and outcome of trials below:*

Drug Name and Dose	Dose	Dates	Outcome

- ☐ No. *Rationale for use:* _____

Additional information

Note: If approved, approval will be given in 12 month increments.

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 Xatmep likely be the most effective option for this patient?

- ☐ No
- ☐ Yes, because: _____

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

- ☐ No
- ☐ Yes, because: _____

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