

# 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.

## Yondelis<sup>®</sup> (trabectedin)

### Member

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

ID #: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Requesting Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician NPI: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Product and Billing Information

New request  Continuation request

Drug product:  Yondelis 1 mg/vial

Dose (mg/kg): \_\_\_\_\_

Frequency: \_\_\_\_\_

Weight: \_\_\_\_\_

Date of last dose: \_\_\_\_\_

Date of next dose: \_\_\_\_\_

BSA (m<sup>2</sup>): \_\_\_\_\_

Administration:  Physician's Office

Outpatient Infusion

Facility: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax #: \_\_\_\_\_

Home infusion

Agency: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax #: \_\_\_\_\_

Billing:  Physician Buy and Bill

Facility 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 have unresectable or metastatic leiomyosarcoma or liposarcoma
2. Must first try an anthracycline-containing regimen

**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.

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**Additional information**

When authorized, the covered dose is 1.5 mg/m<sup>2</sup> body surface area as a 24-hour intravenous infusion, every 3 weeks through a central venous line.

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**Priority Health Precertification Documentation**

**A. What condition is this drug being requested for?**

- unresectable or metastatic leiomyosarcoma
- unresectable or metastatic liposarcoma
- Other – rationale for use: \_\_\_\_\_

**B. Which of the following drugs has the patient tried?**

- Daunorubicin
- Doxorubicin
- Epirubicin
- Idarubicin