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.

Yondelis® (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^2): _____

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.

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

Updated 12/2017
Last reviewed 01/2020

Additional information

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

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

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