

# Medicare Part B 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:  **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<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): \_\_\_\_\_

### Priority Medicare plans

**Note:** Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

WPS Medicare LCD: Chemotherapy Drugs and their Adjuncts (L37205)

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**Priority Health Precertification Documentation**

**A. What is the condition this drug is prescribed for?**

Unresectable or metastatic liposarcoma or leiomyosarcoma that have previously received an anthracycline-containing regimen

*Other – the patient's condition is:* \_\_\_\_\_