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.

Yonsa® (abiraterone)

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: ☐ Yonsa 125 mg tablet

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, the patient must meet the following criteria:

1. Must be used for a medically accepted indication*
2. Must have evidence of disease progression
3. Must have Eastern Cooperative Oncology Group (ECOG) performance standard of 0 to 2
4. Must have a PSA level greater than 5ng/ml
5. Must not have any of the following:
    a. Eastern Cooperative Oncology Group (ECOG) performance status greater than or equal to 3
    b. Severe hepatic impairment
    c. NYHA Class III or IV heart failure
    d. History of adrenal or pituitary gland disorders

Additional information

Note: When coverage criteria are met, coverage duration is 8 months

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2020
Last reviewed 03/2020

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 for a drug or biologic used in an anti-cancer chemotherapeutic regimen is a use 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.)
- supported by one of the following references (known as compendia): National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Micromedex DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology, or Lexi-Drugs
- –– *or* –– supported in peer-reviewed medical literature appearing in regular editions of approved publications

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

- ☐ Metastatic castration-resistant prostate cancer
- ☐ *Other – the patient's condition is:* _____
  Rationale for Other use: _____

B. Will the patient use Yonsa in combination with methylprednisolone?

- ☐ Yes
- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

C. Will the patient receive a gonadotropin-releasing hormone analog with Yonsa or has the patient had a bilateral orchiectomy?

- ☐ Yes
- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

D. Does the patient have evidence of disease progression?

- ☐ Yes
- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

E. Does the patient have a PSA level greater than 5 ng/mL?

- ☐ Yes **Date**: _____ **Level**: _____ ng/mL
- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

D. Which of the following criteria apply to this patient?

- ☐ ECOG performance status ≥ 3
- ☐ Severe hepatic impairment ***Rationale for use:*** _____
- ☐ NYHA Class III or IV heart failure
- ☐ History of adrenal or pituitary gland disorders

- ☐ None of the above

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F. Does the patient have an ECOG performance standard of 0 to 2?

☐ Yes ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

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 Yonsa likely be the most effective option for this patient?

☐ No

☐ Yes, because: _____

_____

_____

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

☐ No

☐ Yes, because: _____

_____

_____

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Last reviewed 03/2020