PriorityHealth

Pharmacy 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.

Zejula® (niraparib)

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: ☐ Zejula 100 mg capsule

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for Zejula is $163.89 per capsule. The annual cost of treatment with Zejula is over $175,000 per year.

Oral oncology partial fill program

Each fill of Zejula is limited to a 14 day supply at any network pharmacy. Patients are responsible for applicable deductible and copayments.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must have diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer, and
2. Must have platinum-sensitive disease (patients who relapse ≥ 6 months after initial chemotherapy), and
3. Have completed at least 2 prior platinum-based therapy regimens, and
4. Are currently in partial or complete response, and
5. Will initiate therapy no later than 8 weeks after their most recent platinum-containing regimen.

For continuation, patient must meet the following requirements:

1. Must meet precertification requirements listed above.
2. Must have no evidence of disease progression or unacceptable adverse reactions.

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. No changes made since 07/2017

Last reviewed 11/2019

PriorityHealth

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Recurrent epithelial ovarian cancer
- ☐ Recurrent fallopian tube cancer
- ☐ Recurrent primary peritoneal cancer
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. What platinum-based therapy has patient completed?

Drug regimen: _____ Dates: _____
Outcome: _____

Drug regimen: _____ Dates: _____
Outcome: _____

Drug regimen: _____ Dates: _____
Outcome: _____

C. Is Zejula being used for maintenance treatment after a partial or complete response to previous treatment?

- ☐ Yes, *please explain:* _____
- ☐ No

Priority Health Recertification Documentation

A. Please fax medical chart notes documenting disease stability and tolerability of the Zejula.

Additional Information

Authorization period is 1 year. For continued approval patient will need to meet continuation criteria annually.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 07/2017
Last reviewed 11/2019