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.

Zelboraf® (vemurafenib)

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

Start date (or date of next dose): _____
Date of last dose (if applicable): _____

Drug product: ☐ Zelboraf 240 mg tablet

Dosing frequency: _____

Precertification Requirements

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 be 18 years of age or older
3. Must have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1 (excluding patients with Erdheim-Chester disease)
4. Must have baseline ECG, electrolytes (i.e., potassium, magnesium, calcium), liver enzymes (i.e., transaminases, alkaline phosphatase), and bilirubin within clinically acceptable limits AND continue to be monitored throughout treatment

Additional information

Note: When criteria are met, duration of approval is 1 year. Zelboraf has a quantity limit of #240 tablets per 30 days

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 01/2019
Last reviewed 01/2019

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?

- ☐ Melanoma (unresectable or metastatic) with BRAF V600E mutation as detected by an FDA-approved test
- ☐ Erdheim-Chester Disease (ECD) with BRAF V600 mutation
- ☐ *Other – the patient's condition is:* _____

Rationale for Other use: _____

B. Is the patient's ECOG performance status 0 or 1? (not required for patients with Erdheim-Chester disease)

- ☐ Yes.
  - ☐ 0: Fully active, able to carry on all pre-disease performance without restriction
  - ☐ 1: Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature (e.g. light house work, office work)
  - ☐ 2: Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours
  - ☐ 3: Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
  - ☐ 4: Completely disabled; cannot carry on any self-care; totally confined to bed or chair
- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

C. Are the following tests and laboratory results within acceptable limits?

- ☐ Baseline ECG
- ☐ Electrolytes (including potassium, magnesium, and calcium)
- ☐ Baseline liver enzymes (transaminases, alkaline phosphatase)
- ☐ Bilirubin
- ☐ None. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

D. Will an ECG, electrolytes, liver enzymes and bilirubin be continually monitored throughout treatment?

- ☐ Yes. ECG and electrolytes should be checked on day 15 of Zelboraf treatment, monthly for the first 3 months following treatment initiation, and then every 3 months (or more often if clinically necessary). Liver enzymes and bilirubin should be checked monthly after Zelboraf is started (or more often if clinically necessary)
- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

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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 Zelboraf likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using Zelboraf, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

_____

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Updated 01/2019
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