Priority Health

Medicare Medical (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**

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.

Oncology Drug Request

Member Information

Last Name: _____ First Name: _____

ID #: _____ DOB: _____

Primary Care Physician: _____ Gender assigned at birth: ☐ Male ☐ Female

Provider Information

Requesting Provider: _____ Phone: _____ Fax: _____

Address: _____

NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Drug and Billing Information *(Please fill out the following information)*

☐ New request ☐ Continuation request - **Original therapy start date**: _____

Drug product: _____ **HCPCS Code:** _____

ICD-10 Code(s): _____

Patient Dosing Information:

Date of last dose (if applicable): _____ **Total doses/cycles/duration requested:** _____

Date of next dose (if applicable) _____ **Height:** _____ **Weight:** _____ **BSA:** _____

Dose: _____ **Dose Frequency**: _____

Place of Administration:

☐ Patient self-administration

☐ Physician's office

☐ Outpatient Hospital Facility: _____NPI: _____ Fax:_____

☐ Outpatient Infusion Facility: _____NPI: _____ Fax:_____

☐ Home Infusion Facility: _____NPI: _____ Fax:_____

☐ Other (specify): _____

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Patient to acquire from pharmacy

☐ Physician to acquire from specialty pharmacy and specialty pharmacy to bill:

Specialty Pharmacy: _____ NPI: _____ Fax:_____

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

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Precertification Requirements

Before this drug is covered, the patient must meet certain criteria. Follow the below steps for coverage criteria:

1. Review for applicable coverage criteria within Medicare National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and other Medicare guidance using the Medicare Coverage Database at: https://www.cms.gov/medicare-coverage-database/new-search/search.aspx.

2. Check for additional Priority Health Medicare coverage criteria using the Medical Benefit Drug List (MBDL).

3. Provide medical records supporting the request, including all the following:
    a. ECOG score
    b. Cancer stage (include T/N/M where necessary to follow the NCCN recommended use)
    c. Previous therapies tried and outcomes of trial
    d. Mutation and/or other testing where recommended and/or necessary to follow the NCCN recommended use (e.g., EGFR/ALK and PD-L1 testing for non-small cell lung cancer)

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, Lexi-Drugs, and Clinical Pharmacology) require supporting evidence for coverage. Please provide published peer-reviewed literature that supports the appropriateness of the drug, including dosing and/or route of administration to be used for the identified indication.

National and Local Coverage Determination/Article Criteria

Priority Health complies with NCDs, LCDs, LCAs, and general coverage and benefit conditions included in Traditional Medicare law for Part B drugs. Use the Medicare Coverage Database (MCD) to review applicable coverage policies for the requested drug based on your jurisdiction: https://www.cms.gov/medicare-coverage-database/search.aspx.

LCD and LCA criteria are established by Medicare Administrative Contractors (MACs) based on the state or other jurisdiction. **The LCD/LCA for the state of Michigan is policy L37205: Chemotherapy Drugs and their Adjuncts**

Medically accepted indication

If no NCD, LCD, or LCA criteria are available for the state or jurisdiction in which the member is receiving services, Priority Health Medicare creates coverage criteria based on CMS-approved compendium and current evidence in widely used treatment guidelines or clinical literature. This includes a review for a medically accepted indication, defined in the Medicare Benefit Policy Manual Chapter 15 § 50.

Priority Health Precertification Documentation

A. Is the drug being utilized per the NCCN recommended use (order or combination)?

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

B. Is the drug listed as Category 1 or 2A in NCCN?

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

C. What is the patient's ECOG score? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

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D. What condition is this drug being requested for? ***Answer any applicable questions based on condition.***

☐ Bladder Cancer
1. **Is it muscle or non-muscle invasive?** ☐ Muscle ☐ Non-Muscle
2. **Is the patient platinum eligible?** ☐ Yes ☐ No
3. **Is the patient PD-L1 positive?** ☐ Yes ☐ No

☐ Breast cancer
1. **Is it ER and/or PR-positive?** ☐ Yes ☐ No
2. **Is it HER2 negative or positive?** ☐ Negative ☐ Positive
3. **Did patient receive endocrine therapy in the past year?** ☐ Yes ☐ No

☐ Chronic Myeloid Leukemia
1. **Is it chronic, accelerated, or blast phase?** ☐ Chronic ☐ Accelerated ☐ Blast
2. **Is it low, intermediate, or high-risk?** ☐ Low ☐ Intermediate ☐ High
3. **Has the patient tried imatinib?** ☐ Yes ☐ No

☐ Colon cancer
1. **Is it unresectable?** ☐ Yes ☐ No
2. **Is it KRAS wild-type?** ☐ Yes ☐ No
3. **For Erbitux® and Vectibix®, are tumors left-sided only?** ☐ Yes ☐ No

☐ Esophageal / esophagogastric junction cancers
1. **What is the histology?** ☐ Squamous ☐ Both ☐ Adenocarcinoma
2. **Is the patient a surgical candidate?** ☐ Yes ☐ No

☐ Gastric cancer

☐ Head and neck cancer
1. **What area is affected?** ☐ Nasopharyngeal ☐ Non-Nasopharyngeal

☐ Hepatocellular carcinoma (HCC)

☐ Malignant melanoma

☐ Non-Hodgkin Lymphomas (B-cell lymphomas)
1. **For MZL, what is the type of lymphoma?** ☐ Gastric ☐ Nongastric ☐ Nodal ☐ Splenic

☐ Non-Small Cell Lung Cancer (NSCLC)
1. **Is the patient PD-L1 positive?** ☐ Yes ☐ No
2. **What is the histology?** ☐ Squamous ☐ Both ☐ Adenocarcinoma
3. **Does patient have an EGFR or ALK mutation?** ☐ Yes ☐ No ☐ Not tested

If not tested, provide rationale as to why: _____

☐ Prostate cancer
1. **Castration-sensitive or castration-resistant disease?** ☐ Sensitive ☐ Resistant
2. **Is it adenocarcinoma?** ☐ Yes ☐ No
3. **For metastatic disease, indicate type of metastases:** ☐ Bone ☐ Visceral
4. **For Provenge® requests:**
   a. **Is the patient's life expectancy > 6 months?** ☐ Yes ☐ No
   b. **Is the condition asymptomatic/minimally symptomatic?** ☐ Yes ☐ No

☐ Rectal cancer

☐ Renal cell carcinoma (RCC)
1. **Is it clear or non-clear cell?** ☐ Clear cell ☐ Non-clear cell

☐ Small Cell Lung cancer
1. **What is the stage of the disease?** ☐ Extensive ☐ Limited

☐ Other: _____

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E. What is the cancer stage? ☐ 1 ☐ 2 ☐ 3 ☐ 4; T_____ N_____ M_____

F. Is this first, second, or subsequent-line therapy? ☐ First ☐ Second ☐ Subsequent

G. List the other treatment tried and failed with the associated outcome (failure, intolerance, etc.)

	Drug / Regimen	Outcome
☐ Drug 1		
☐ Drug 2		
☐ Drug 3		

Additional information

Note: When coverage criteria are met, coverage duration is 1 year or as medically necessary. Dose will be approved according to the FDA-approved labeling or within accepted standards of medical practice.

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

Do you believe one or more of the requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would this drug likely be the most effective option for this patient?
☐ No
☐ Yes, because:_____

If the patient is currently using this drug, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ No
☐ Yes, because:_____

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