Priority Health

Medical 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)**

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

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Prov. Phone: _____ Prov. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Physician Signature: _____ Date: _____

Product and Billing Information

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

Drug product: _____

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 infusion Facility: _____NPI: _____ Fax:_____

☐ Home infusion Agency: _____NPI: _____ Fax:_____

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy: _____NPI: _____ Fax:_____

ICD-10 Diagnosis Code(s): _____

HCPCS Code: _____

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

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Updated 01/2022
Last reviewed 01/2023

Precertification Requirements

Patient must meet all of the following criteria (supporting documentation is required):

1. Must have a Food and Drug Administration (FDA) approved indication for use or use must be consistent with National Comprehensive Cancer Network guidelines category 1 or 2A recommendations for cancer type, cancer stage, line of therapy and performance status. Consideration for coverage which do not meet the above criteria require submission from two peer-reviewed medical journal articles.
2. Coverage for National Comprehensive Cancer Network guidelines category 2B recommendations will be considered after failure of category 1 or 2A recommendations or when higher recommendations are not indicated.
3. Prescribed by an oncologist, hematologist, or another board-certified prescriber with qualifications to treat specified cancer type.
4. Appropriate genetic testing results to support use based on FDA approved package labeling and NCCN guidelines.
5. Must have an Eastern Cooperative Oncology Group (ECOG) score between 0 and 2.
6. Additional criteria as stated on drug-specific prior authorization forms on Priority Health's website.

When the above criteria is met, initial approval for coverage of the requested medication will be for no more than 12 months.

For continuation, patient must meet the following requirements:

1. Current chart notes must be provided detailing response and compliance to therapy.
2. Coverage may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR disease progression has occurred after initiation of drug therapy.

When the above continuation criteria is met, approval for coverage of the requested medication will be for no more than 12 months.

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.

Priority Health Precertification Documentation

1. What condition is this drug being requested for?

_____

2. Is use consistent with one or more of the following?

- ☐ FDA approved indication
- ☐ NCCN guideline category 1 or 2A recommendation
- ☐ NCCN guideline category 2B
- ☐ Off-label (two peer-reviewed medical journal articles must be submitted to support use)

3. What previous treatment has the patient used?
(e.g. chemotherapy, immunotherapy, targeted oral therapy, stem cell transplant)

Previous therapy: _____	Date: _____
Previous therapy: _____	Date: _____
Previous therapy: _____	Date: _____
Previous therapy: _____	Date: _____
Previous therapy: _____	Date: _____

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4. What is the patient's Eastern Cooperative Oncology Group (ECOG) performance status?

- ☐ 0, Fully active, able to carry on activity without restriction
- ☐ 1, Restricted in heavy activity, but able to carry out work of light nature, e.g. house or office work
- ☐ 2, Ambulatory and capable of self-care, but unable to carry out any work activities
- ☐ ≥ 3, capable of limited self-care or completely disabled
- ☐ Other:_____ (please provide other measure of disease impact such as Karnofsky performance status.

5. Have chart notes and lab records been submitted with this request?

- ☐ Yes
- ☐ No

Request to continue a previously authorized approval

1. Has the patient been compliant with therapy?

- ☐ Yes
- ☐ *No; rationale for continued use:*_____

2. Has the patient had a response to therapy?

- ☐ Yes
- ☐ *No; rationale for continued use:*_____

3. Has the patient's condition progressed since starting therapy?

- ☐ Yes
- ☐ *No; rationale for continued use:*_____

4. Documentation of clinical outcomes must be submitted to Priority Health

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