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INJECTABLE AND HEALTH CARE ADMINISTERED ONCOLOGY AGENTS
Preauthorization Request
(Preauthorization is not a guarantee of payment)

SECTION I – General Information

Today's Date: / /	☐ New request
Fax completed form to:**1-866-805-4150 toll free**	☐ Re-Authorization

Level of Urgency:

Standard Request (Routine Care)—Care/treatment that is not emergent, urgent, or preventive in nature.

Expedited Request—Care/treatment that is emergent or the application of the timeframe for making Standard/Routine or nonlife-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
- In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

For Expedited Request, Please Explain:

SECTION II – Member Information

Patients Name:	Member ID:	**Patient Information**: DOB: Sex: Age: Weight: ☐ lbs. ☐ Kg Will the patient self-administer the requested medication? ☐ Yes ☐ No
Patients Address:	Is CBC primary payer: ☐ Yes ☐ No	

Plan Type:

☐ PPO ☐ POS ☐ KHPC ☐ CHIP (aka Capital Cares 4Kids)

☐ Traditional ☐ Comprehensive ☐ Special Care ☐ Other* _____

NOTE: For all Medicare Advantage products, please contact Prime Therapeutics at https://www.covermymeds.com/main or via phone at 1-866-260-0452.

SECTION III – Provider Information Required

Requesting Provider Name: **Address**:	**Requesting Provider CBC #**_____ **NPI #** _____
Telephone #:	Secure Fax #:
Office Contact Name:	Office Contact Telephone #:

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Is the Rendering/Servicing provider different? ☐ No ☐ Yes – Complete rendering provider information below.	
Rendering Provider Name: **Address**: **Telephone:**	**Rendering Provider CBC #**_____ **NPI #** _____
Site of Service: ☐ MD Office ☐ Home Health ☐ Non-hospital affiliated, outpatient infusion center ☐ Hospital affiliated, outpatient infusion center ☐ Other: Specify _____ **Please refer to MP 3.016 for Site of Service requirements.*	**Check all that apply and include all applicable documentation:** ☐ There are contraindications to a less intensive site of care. ☐ A less intensive site of care is not appropriate for the patient's condition. ☐ Patient is being treated with a drug that cannot be administered in a less intensive site of care concurrently. ☐ Less intensive site of care is not available. **Please include all applicable documentation.*

SECTION IV – Preauthorization Requirements and Clinical Criteria

Prescribed in consultation with a specialist? ☐ No ☐ Yes Specialty: _____

☐ New to therapy ☐ Continuing therapy*: Initial start __/__/__ ☐ Reinitiating therapy: Last treatment __/__/__ *Please include documentation for changes in dose.	**Route of Administration:** ☐ Intravenous (IV) ☐ Injection (Sub Q or IM) ☐ Oral (PO) or Enteral ☐ Other: Specify _____
HCPC Code(s):	**Diagnosis Code(s**):
Medication requested:	**Indication:**

Does the patient have late stage metastatic disease? ☐ Yes ☐ No

For patients with late stage metastatic disease (Stage IV), please refer to MP 2.373 Step Therapy Treatment in Cancer, Including Treatments for Stage Four, Advanced Metastatic Cancer and Severe Related Health Conditions for additional guidance.

Type of drug requested: ☐ Brand name ☐ Generic ☐ Biosimilar ☐ Other: Specify _____

Initial start date of therapy:	Anticipated date of **next administration:**

Dosing period for request: Start Date: End Date	**Dosing Information:** Dose: Strength: Frequency: Quantity requested per month:

<u>Attach documentation demonstrating the medical nessicity of the requested drug.</u> Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max.)

Has the patient had **medical testing** completed for use of this drug? (labs, imagining) ☐ Yes ☐ No

Results:_____

Is drug being requested for an "**off label" indication**? ☐ Yes ☐ No

If yes, please see Medical Policy 2.103 and include any applicable documentation.

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Please list any previous medications that were **tried and failed**. Include reason for discontinuation (intolerance, hypersensitivity, inadequate response etc.). Please attach documentation.

Drug(s) and strength:

Documentation of failure:

Injectable and Health Care Administered Oncology

☐ Kyprolis® (carfilzomib)
☐ Darzalex® (daratumumab)
☐ Darzalex FasPro™(daratumumab and hyaluronidase-fihj)
☐ Abraxane® (paclitaxel)
☐ Herceptin® (trastuzumab)
☐ Adcetris® (brentuximab vedotin)
☐ Alimta® (pemetrexed)
☐ Kyprolis® (carfilzomib)
☐ Jelmyto™ (mitomycin)
☐ Belnrep™(belantamab mafodotin-blmf)
☐ Monjuvi™ (tafasitamab-cxix)
☐ **Pepaxto®** (melphalan flufenamide)
☐ **Zynlonta™** (loncastuximab tesirine-lpyl)
☐ **Rylaze™** (asparaginase erwinia chrysanthemi (recombinant)-rywn
☐ Rybrevant™ (amivantamab-vmjw)

☐ Other:_____

Is the patient currently being treated with the requested drug? ☐ Yes ☐ No

Is there risk to the patient if the therapy is changed? ☐ Yes ☐ No

Does the patient have an FDA labeled diagnosis for the requested drug? ☐ Yes ☐ No

Does the requested diagnosis require genetic/specific diagnostic testing (e.g., HER2, EGFR, ALK) in FDA labeling?

If so, has genetic/specific diagnostic testing been performed? ☐ Yes ☐ No

Do the results of the genetic/ specific diagnostic testing indicate therapy with the requested drug is appropriate in FDA labeling? ☐ Yes ☐ No

Is the requested drug FDA labeled as a first-line agent for the requested indication? ☐ Yes ☐ No

Has the patient used the appropriate number and type(s) of prerequisite drug(s) listed in the FDA labeling for the requested indication? ☐ Yes ☐ No

Does the patient have a documented intolerance, FDA labeled contraindication, or hypersensitivity to ALL of the required prerequisite drug(s) listed in the FDA labeling for the requested indication? ☐ Yes ☐ No

Is the requested drug approved for use as monotherapy in the FDA labeling for the requested indication? ☐ Yes☐ No

Will the requested drug be used with all agent(s) and/or treatments (e.g., radiation) listed for concomitant use in the FDA labeling for the requested indication? ☐ Yes ☐ No

Does the FDA label include a performance status requirement? ☐ Yes ☐ No

Does the patient meet the performance status requirement in the FDA labeling? ☐ Yes ☐ No

Is the requested indication supported by ALL requirements in either FDA labeling or NCCN 1 or 2A recommended use for the requested drug [i.e., this indication must be supported by ALL requirements in the FDA label or NCCN "Recommended Use" box (e.g., performance status, disease severity, previous failures, monotherapy vs combination therapy, etc.)] ☐ Yes ☐ No

Does the patient have an NCCN 1 or 2A recommended indication [i.e., this indication must be supported by ALL requirements in the NCCN "Recommended Use" box (e.g., performance status, disease severity, previous failures, monotherapy vs combination therapy, etc.)]? ☐ Yes ☐ No

Include all applicable documentation for request.

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Please use a separate form for each drug. To fill out form type or write using blue or black ink **Please fax this form to: 1-866-805-4150** Telephone: 1-800-471-2242	**CONFIDENTIALITY NOTICE**: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 1-800-471-2242. Thank you for your cooperation.
Prior authorization is not a guarantee of payment; benefits and eligibility will apply at the time of claim adjudication.	