Capital BLUE

ONCOLOGY IMMUNOTHERAPY AGENTS
Preauthorization Request
(Preauthorization is not a guarantee of payment)

SECTION I – General Information

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

Capital BLUE

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? ☐ Yes Specialty: _____ ☐ No

☐ 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.

Capital BLUE

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:

Drug:

☐ Bavencio (avelumab)
☐ Imfinzi (durvalumab)
☐ Keytruda (pembrolizumab)
☐ Opdivo (nivolumab)
☐ Tecentriq (atezolizumab)
☐ Yervoy (ipilimumab)
☐ **J**emperli **(**(dostarlimab-gxly)
☐ Other: Specify: _____

Diagnosis

☐ Adjuvant treatment of cutaneous melanoma
☐ Adjuvant treatment of melanoma
☐ BRAF-V600 mutation positive unresectable or metastatic melanoma
☐ BRAF-V600 wild-type unresectable or metastatic melanoma
☐ Bacillus Calmette-Guerin (BCG)-unresponsive, high-risk non-muscle invasive bladder cancer (NMIBC)
☐ Cervical cancer - ☐ Metastatic ☐ Recurrent
☐ Classical Hodgkin lymphoma - ☐ **Refractory** ☐ **Relapsed** ☐ **Progressive**
☐ Colorectal cancer ☐ Unresectable ☐ Metastatic MSH-H or dMMR
☐ Cutaneous squamous cell carcinoma (CSCC) - ☐ Recurrent ☐ Metastatic OR
☐ Locally advanced CSCC and the patient is not a candidate for curative surgery or curative radiation
☐ Endometrial cancer (advanced)
☐ Head and neck squamous cell carcinoma ☐ Metastatic ☐ Recurrent ☐ Unresectable,
☐ Hepatocellular carcinoma (HCC)
☐ Microsatellite instability-high (MCI-H) or mismatch repair deficient (dMMR) metastatic colorectal cancer
☐ Melanoma - ☐ Metastatic ☐ Recurrent ☐ unresectable
☐ Melanoma with involvement of lymph node(s) following complete resection
☐ Merkel cell carcinoma ☐ **Recurrent** locally advanced ☐ Metastatic
☐ Non-small cell lung cancer (NSCLC) - ☐ Metastatic ☐ Recurrent ☐ Unresectable, Stage III
☐ Nonsquamous non-small cell lung cancer (NSCLC) - ☐ Metastatic
☐ Pleural mesothelioma (malignant)
☐ Primary mediastinal large B-cell lymphoma (PMBCL)
☐ **Recurrent** locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma
☐ Recurrent esophageal squamous cell carcinoma cancer
☐ **R**enal cell carcinoma (RCC) - ☐ poor risk; ☐ intermediate; ☐ advanced
☐ Small cell lung cancer - ☐ Metastatic ☐ Extensive stage
☐ Squamous non-small cell lung cancer - ☐ Metastatic
☐ Triple-Negative-Breast Cancer (TNBC) ☐ Metastatic ☐ Recurrent ☐ Unresectable,
☐ Unresectable or metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) cancer
☐ Unresectable or metastatic tumor mutational burden-high [TMB-H (≥ 1- mutations/megabase (mut/Mb] solid tumors

Capital BLUE

☐ Urothelial Cancer - ☐ locally advanced ☐ metastatic
☐ Other: Specify_____

Has the patient had disease progression on or after:
☐ fluoropyrimidine(s)
☐ Eloxatin **(**oxaliplatin)
☐ Camptosar **(**irinotecan)
☐ Nexavar (sorafenib)
☐ Adcetris (brentuximab vedotin)
☐ Alecensa (alectinib)
☐ Xalkori (crizotinib)
☐ Zykadia (ceritinib)
☐ Gilotrif (afatinib)
☐ Iressa (gefitinib)
☐ Tagrisso (osimertinib)
☐ Tarceva (erlotinib)
☐ Herceptin (trastuzumab)
☐ Ogivri (trastuzumab-dkst)
☐ **C**isplatin-containing therapy
☐ Platinum-containing chemotherapy: Specify_____

☐ Other: Specify_____

The requested drug is being used in combination with:
☐ Paraplatin carboplatin
☐ Taxol (paclitaxel)
☐ Abraxane **(**nab-paclitaxel)
☐ Avastin **(**bevacizumab)
☐ Opdivo (nivolumab)
☐ Alimta **(**pemetrexed)
☐ **Cisplatin (platinol)**
☐ **P**latinum-containing chemotherapy: Specify_____
☐ Other: Specify_____

Will the requested drug be used as first-line treatment? ☐ Yes ☐ No If no, please attach documentation demonstrating rationale for selection of drug.
Does the patients diagnosis have other satisfactory alternative treatment options? ☐ Yes ☐ No
Has the patient been previously treated for the diagnosis? ☐ Yes ☐ No (Attach documentation)
Is the patient currently being treated with the requested drug? ☐ Yes ☐ No
Is the patient at risk if they change therapy? ☐ Yes ☐ No
Will the requested agent be used as a single agent? ☐ Yes ☐ No
Is the patient 12 years of age or older? ☐ Yes ☐ No
Does the patient have solid tumors? ☐ Yes ☐ No
Does the patient have papillary tumors? ☐ Yes ☐ No
Is the patient ineligible for or elected not to undergo cystectomy? ☐ Yes ☐ No
Is the cancer not curable by surgery or radiation ☐ Yes ☐ No
Have the tumors progressed following prior treatment? ☐ Yes ☐ No

Capital BLUE

Does the patient have metastatic disease? ☐ Yes ☐ No
Has the patient had a complete resection? ☐ Yes ☐ No
Is the patient a candidate for a surgical resection? ☐ Yes ☐ No
Is the patient a candidate for definitive chemoradiation? ☐ Yes ☐ No
Does the patient's disease have involvement of lymph nodes? ☐ Yes ☐ No
Is there pathologic involvement of regional lymph nodes of more than 1 mm? ☐ Yes ☐ No
Has the patient had complete surgical resection including total lymphadenectomy? ☐ Yes ☐ No
Does the patient have active autoimmune disease? ☐ Yes ☐ No
Does the patient have ALK positive disease? ☐ Yes ☐ No (Attach documentation)
Does the patient have EGFR positive disease? ☐ Yes ☐ No (Attach documentation)
Do the tumors express PD-L1 as determined by an FDA approved genetic test? ☐ Yes ☐ No (Attach documentation)
If yes, is Tumor Proportion Score (TPS) ≥ 1% ☐; ≥ 10% ☐; ≥ 50%] ☐
Combined Positive Score (CPS) ≥ 1 ☐; ≥ 10 ☐
Have unresectable or metastatic tumor mutational burden-high [TMB-H (≥ 1- mutations/megabase (mut/Mb] solid tumors, as determined by an FDA-approved test, progressed following prior treatment with no satisfactory alternative treatment options ☐ Yes ☐ No
Does the tumors have the following aberrations: EGFR ☐ ALK ☐ ROS1 ☐
Is the cancer stage III and patient not a candidate for surgical resection or definitive chemoradiation ☐ Yes ☐ No
Does the patient have HER2 positive disease? ☐ Yes ☐ No (Attach documentation)
Has the patient had progression of disease after platinum-based chemotherapy **and** at least one other line of therapy? ☐ Yes ☐ No
Has the patient had disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy? ☐ Yes ☐ No
Has the patient's disease progressed following concurrent platinum-based chemotherapy **and**
radiation therapy? ☐ Yes ☐ No
Is the patient's disease refractory or has relapsed following two or more prior therapies? ☐ Yes ☐ No (Attach documentation)
Has the patient previously received anti-angiogenic therapy? ☐ Yes ☐ No
Has the patient had autologous hematopoietic stem cell transplantation (auto-HSCT)? ☐ Yes ☐ No
Has the patient used 3 or more lines of systemic therapy including auto-HSCT? ☐ Yes ☐ No
Is the requested indication supported by ALL requirements in either FDA labeling or NCCN 1 or 2A recommended use for the requested agent? ☐ Yes ☐ No
Does the patient have another FDA labeled indication for the requested agent? ☐ Yes ☐ No
Does the patient have any FDA labeled contraindications to therapy with the requested agent? ☐ Yes ☐ No

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

Prior authorization is not a guarantee of payment; benefits and eligibility will apply at the time of claim adjudication.