Print Reset

Self-Administered Oncology Agents
Choice Prior Authorization Request Prescriber Fax
Fax this form to 888-272-1349

Prime Therapeutics Management LLC partners with CoverMyMeds to allow for the submission of electronic PA requests. **For faster coverage determinations, go to www.CoverMyMeds.com.**

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews. Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information visit web.primetherapeutics.com/provider/forms or primetherapeutics.com/commercial-formularies.

What is the priority level of this request?

☐ Standard

☐ Date of service (if applicable): _____

☐ Urgent (**Note:** Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Patient Last Name: _____

Patient First Name: _____

Patient ID: _____ Date of Birth: _____ Patient Phone: _____

Patient Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Height: _____ ☐ in. ☐ cm Weight: _____ ☐ lbs. ☐ kg

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Specialty: _____ Email: _____

Prescriber NPI: _____ DEA: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

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Patient's Name (Last, First): _____

DRUG INFORMATION

Drug Name: _____ Drug Form: _____

Drug Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

Number of Refills: _____ Day Supply: _____

☐ New Therapy ☐ Renewal If renewal, date therapy initiated: _____

If renewal, duration of therapy (specific dates): _____ to _____

CRITERIA FOR ALL REQUESTS

Note: Please attach any additional information that should be considered with this request.

Patient's Diagnosis:

ICD Code: _____

ICD Description: _____

1. What is the patient's weight? _____ (kg)
2. What is the patient's body surface area (BSA) in square meters (m^2)? _____
3. Has the patient been treated with the requested agent in the past 180 days?
   ☐ Yes ☐ No

   If Yes, is the patient at risk if therapy is changed?
   ☐ Yes ☐ No

   If Yes, please explain:

   _____
4. Is the patient's age within FDA labeling for the requested indication for the requested agent?
   ☐ Yes ☐ No

   If No, is there information in support of using the requested agent for the patient's age?
   ☐ Yes ☐ No

   If Yes, please provide supporting information:

   _____
5. Does the patient have any FDA-labeled contraindications to the requested agent?
   ☐ Yes ☐ No

   If Yes, please specify FDA-labeled contraindications:

   _____

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Patient's Name (Last, First): _____

6. 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).

_____

7. Please list all medications that the patient has previously tried and had an inadequate response, intolerance or contraindication to for the treatment of this diagnosis. Please specify whether the patient has tried brand-name products, generic products, or over-the-counter products.

   Medication: _____

   Outcome of trial: _____

   Date (from): _____ Date (to): _____

   Medication: _____

   Outcome of trial: _____

   Date (from): _____ Date (to): _____

   Medication: _____

   Outcome of trial: _____

   Date (from): _____ Date (to): _____

8. Does the patient have an FDA-approved diagnosis for the requested agent?
   ☐ Yes ☐ No

   If No, does the patient have an indication for use that is supported by NCCN 1 or 2A recommended use, AHFS, DrugDex level of evidence of 1 or 2A (i.e., this indication must be supported by **all** requirements in the compendia [e.g., performance status, disease severity, previous failures, monotherapy vs combined therapy, etc.]) for the requested agent?
   ☐ Yes ☐ No

   If **Yes**, please specify:

   _____

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9. Does the requested indication require a genetic/specific diagnostic testing per FDA labeling or compendia (NCCN 1 or 2A recommended use, AHFS, DrugDex level of evidence of 1 or 2A) for the requested agent?
☐ Yes ☐ No

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

      If Yes, do the results of the genetic/specific diagnostic testing indicate therapy with the requested agent is appropriate?
      ☐ Yes ☐ No

         If Yes, please specify:

         _____

10. Is the requested agent being used as monotherapy **and** is supported for use as monotherapy in FDA labeling or compendia (NCCN 1 or 2A recommended use, AHFS, DrugDex level of evidence of 1 or 2A) for the requested indication?
☐ Yes ☐ No

   If No, will the requested agent be used as combination therapy and is supported as combination therapy (including all agents and/or treatments [e.g., radiation]) in FDA labeling or compendia (NCCN 1 or 2A recommended use, AHFS, DrugDex level of evidence of 1 or 2A) for the requested indication?
   ☐ Yes ☐ No

      If Yes, please specify concomitant treatments:

      _____

11. Is the requested agent one of the following (i.e., a brand agent with a generic equivalent): Afinitor, Afinitor Disperz, Gleevec, Iressa, Nexavar, Phyrago, Revlimid, Sprycel, Sutent, Tarceva, Targretin, Tykerb, Votrient, Xeloda, or Zytiga?
☐ Yes ☐ No

   If Yes, does the patient have an intolerance or hypersensitivity to the generic equivalent that is not expected to occur with the requested brand agent?
   ☐ Yes ☐ No

      If Yes, please explain the patient's intolerance or hypersensitivity:

      _____

      If No, does the patient have an FDA-labeled contraindication to the generic equivalent that is not expected to occur with the requested brand agent?
      ☐ Yes ☐ No

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If Yes, please specify the patient's FDA-labeled contraindication:

_____

If No, is there information to support the use of the requested brand agent over the generic equivalent?
☐ Yes ☐ No

If Yes, please provide supporting information:

_____

12. Will the requested agent be used as a first-line agent and is FDA-labeled or supported by compendia (NCCN 1 or 2A recommended use, AHFS, DrugDex level of evidence of 1 or 2A) as a first line agent for the requested indication?
☐ Yes ☐ No

If No, has the patient tried and had an inadequate response to the appropriate number and type(s) of prerequisite agent(s) listed in the FDA labeling or compendia (NCCN 1 or 2A recommended use, AHFS, DrugDex level of evidence of 1 or 2A) for the requested indication?
☐ Yes ☐ No

If Yes, please specify:

_____

If No, does the patient have an intolerance or hypersensitivity to the appropriate number and type(s) of prerequisite agent(s) listed in the FDA labeling or compendia (NCCN 1 or 2A recommended use, AHFS, DrugDex level of evidence of 1 or 2A) for the requested indication?
☐ Yes ☐ No

If Yes, please explain the patient's intolerance or hypersensitivity:

_____

If No, does the patient have an FDA-labeled contraindication to ALL of the required prerequisite agent(s) listed in the FDA labeling or compendia for the requested indication?
☐ Yes ☐ No

If Yes, please specify the patient's FDA-labeled contraindication:

_____

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Patient's Name (Last, First): _____

CRITERIA FOR AUGTYRO AND IBTROZI

13. Does the patient have a diagnosis of Metastatic ROS1-positive non-small cell lung cancer (NSCLC)?
☐ Yes ☐ No

If Yes, does the patient's medication history indicate use of Rozlytrek or Xalkori?
☐ Yes ☐ No

If Yes, please specify:

_____

If No, does the patient have an intolerance or hypersensitivity to Rozlytrek or Xalkori?
☐ Yes ☐ No

If Yes, please explain the patient's intolerance or hypersensitivity:

_____

If No, does the patient have an FDA-labeled contraindication to both Rozlytrek and Xalkori?
☐ Yes ☐ No

If Yes, please specify the patient's FDA-labeled contraindication:

_____

CRITERIA FOR BOSULIF, DANZITEN, NILOTINIB D-TARTRATE, NILOTINIB (GENERIC TASIGNA) OR TASIGNA

14. Has the patient been previously treated with Bosulif, Danziten, nilotinib d-tartrate, nilotinib or Tasigna for Chronic Myeloid Leukemia (CML)?
☐ Yes ☐ No

If Yes, please specify:

_____

15. Is the patient a newly diagnosed adult or pediatric patient with Philadelphia chromosome positive chronic myeloid leukemia in chronic phase?
☐ Yes ☐ No

If Yes, does the patient's medication history indicate use of generic imatinib or generic dasatinib?
☐ Yes ☐ No

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If Yes, please specify:

_____

If No, does the patient have an intolerance or hypersensitivity to generic imatinib or generic dasatinib?

☐ Yes ☐ No

If Yes, please explain the patient's intolerance or hypersensitivity:

_____

If No, does the patient have an FDA-labeled contraindication to both generic imatinib and generic dasatinib?

☐ Yes ☐ No

If Yes, please specify the patient's FDA-labeled contraindication:

_____

If No, is there information supporting use of Bosulif or Tasigna over generic imatinib or generic dasatinib?

☐ Yes ☐ No

If Yes, please provide supporting information:

_____

16. If the request is for Bosulif **capsules**, is the dose less than 500 mg?

☐ Yes ☐ No

If Yes, has the patient tried and had an inadequate response to Bosulif tablets?

☐ Yes ☐ No

If No, does the patient have an intolerance, hypersensitivity or contraindication to Bosulif tablets that is not expected to occur with the requested agent?

☐ Yes ☐ No

If Yes, please specify: _____

If No, is support for the use of the capsules over the Bosulif tablets (e.g., swallowing difficulties)?

☐ Yes ☐ No

If Yes, please provide supporting information:

_____

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Patient's Name (Last, First): _____

CRITERIA FOR IMBRUVICA

17. If the requested agent is Imbruvica 140 mg or 280 mg **tablets**, has the patient tried and had an inadequate response to Imbruvica 140 mg **capsules**?

☐ Yes ☐ No

If No, does the patient have an intolerance or hypersensitivity to Imbruvica capsules that is not expected to occur with the Imbruvica tablets?

☐ Yes ☐ No

If Yes, please explain the patient's intolerance or hypersensitivity:

_____

If No, does the patient have an FDA-labeled contraindication to Imbruvica capsules that is not expected to occur with Imbruvica tablets?

☐ Yes ☐ No

If Yes, please specify the patient's FDA-labeled contraindication:

_____

If **No**, please provide support for the use of the requested agent over Imbruvica 140 mg capsules?

_____

CRITERIA FOR IBRANCE

18. Does the patient have a diagnosis of advanced or metastatic breast cancer?

☐ Yes ☐ No

If Yes, does the patient's medication history indicate use of Kisqali, Kisqali Femara Pack, or Verzenio?

☐ Yes ☐ No

If Yes, please specify:

_____

If No, does the patient have an intolerance or hypersensitivity to Kisqali, Kisqali Femara Pack, and Verzenio?

☐ Yes ☐ No

If Yes, please explain the patient's intolerance or hypersensitivity:

_____

If No, does the patient have an FDA-labeled contraindication to both Kisqali, Kisqali Femara Pack, and Verzenio?

☐ Yes ☐ No

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If Yes, please specify the patient's FDA-labeled contraindication:

_____

If No, is there information supporting use of Ibrance over Kisqali, Kisqali Femara Pack, or Verzenio?

☐ Yes ☐ No

If Yes, please provide supporting information:

_____

CRITERIA FOR IMKELDI

19. Has the patient tried and had an inadequate response to imatinib tablets?

☐ Yes ☐ No

If **No**, does the patient have an intolerance, hypersensitivity, or contraindication to imatinib tablets that is not expected to occur with the requested agent?

☐ Yes ☐ No

If **Yes**, please specify: _____

If **No**, please provide support for the use of the requested agent over imatinib tablets:

_____

CRITERIA FOR OGSIVEO

20. Does the patient have a diagnosis of Desmoid tumors?

☐ Yes ☐ No

If Yes, does the patient's medication history indicate use of generic sorafenib?

☐ Yes ☐ No

If Yes, please specify: _____

If No, does the patient have an intolerance or hypersensitivity to generic sorafenib?

☐ Yes ☐ No

If Yes, please explain the patient's intolerance or hypersensitivity:

_____

If No, does the patient have an FDA-labeled contraindication to generic sorafenib?

☐ Yes ☐ No

If Yes, please specify the patient's FDA-labeled contraindication:

_____

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Patient's Name (Last, First): _____

CRITERIA OR PHYRAGO

21. Has the patient tried and had an inadequate response to generic dasatinib?
☐ Yes ☐ No

If **No**, does the patient have an intolerance, hypersensitivity, or contraindication to generic dasatinib that is not expected to occur with the requested agent?
☐ Yes ☐ No

If **Yes**, please specify: _____

If **No**, please provide support for the use of the requested agent over generic dasatinib:

_____

CRITERIA FOR SCEMBLIX

22. Does the patient have a diagnosis of Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase with the T315I mutation?
☐ Yes ☐ No

If Yes, does the patient's medication history indicate use of Iclusig?
☐ Yes ☐ No

If Yes, please specify:

_____

If No, does the patient have an intolerance or hypersensitivity to Iclusig?
☐ Yes ☐ No

If Yes, please explain the patient's intoleranceor hypersensitivity:

_____

If No, does the patient have an FDA-labeled contraindication to Iclusig?
☐ Yes ☐ No

If Yes, please specify the patient's FDA-labeled contraindication:

_____

If No, is there information supporting use of Scemblix over Iclusig?
☐ Yes ☐ No

If Yes, please provide supporting information:

_____

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CRITERIA FOR ZYTIGA/ABIRATERONE

23. If the requested agent is Zytiga/abiraterone 500 mg, has the patient tried and had an inadequate response to generic abiraterone 250 mg tablets?

☐ Yes ☐ No

If No, does the patient have an intolerance or hypersensitivity to generic abiraterone 250 mg tablets that is not expected to occur with the requested agent?

☐ Yes ☐ No

If Yes, please explain the patient's intolerance or hypersensitivity:

_____

If No, does the patient have an FDA-labeled contraindication to generic abiraterone 250 mg that is not expected to occur with the requested agent?

☐ Yes ☐ No

If Yes, please specify the patient's FDA-labeled contraindication:

_____

If **No**, please provide support for the use of the requested agent over generic abiraterone 250 mg tablets:

_____

CRITERIA FOR MEKINIST ORAL SOLUTION

24. Has the patient tried and had an inadequate response to Mekinist oral tablets?

☐ Yes ☐ No

If No, does the patient have an intolerance or hypersensitivity to Mekinist oral tablets that is not expected to occur with the requested agent?

☐ Yes ☐ No

If Yes, please explain the patient's intolerance or hypersensitivity:

_____

If No, does the patient have an FDA-labeled contraindication to Mekinist oral tablets that is not expected to occur with the requested agent?

☐ Yes ☐ No

If Yes, please specify the patient's FDA-labeled contraindication:

_____

If No, is there information to support the use of the requested agent over Mekinist oral tablets (e.g., swallowing difficulties)?

☐ Yes ☐ No

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Patient's Name (Last, First): _____

If Yes, please provide supporting information:

_____

CRITERIA FOR RENEWAL REQUESTS

25. **For Vitrakvi:** has the patient experienced a clinical benefit (i.e., partial response, complete response, or stable disease) from treatment with the requested agent?
    ☐ Yes ☐ No

    If Yes, please explain:

    _____

☐ Attachments

ATTESTATION

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber's Signature: _____ **Date:** _____

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Please fax or mail this form to:

Prime Therapeutics Management LLC
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 1-800-651-8921

Fax this form to 888-272-1349

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