

SA ONCOLOGY PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies 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

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:		Patient Telephone:
Member ID Number:		Group Number:	

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis (ICD code plus description):	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. What is the patient’s weight? _____ (kg)
2. Is the patient currently treated with the requested agent? Yes No
 If yes, was the treatment started on samples? Yes No
 If yes, is the patient currently stable on the requested agent? **Please note, chart notes required**..... Yes No
 If yes, is the patient at risk if therapy is changed? Yes No
 If yes, please specify risk: _____
3. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify contraindication(s): _____
4. Is the patient’s age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, is there support for using the requested agent for the patient’s age for the requested indication? Yes No
 If yes, please provide supporting information: _____
5. Please specify the results of any genetic/diagnostic testing that has been completed for the patient for the requested agent and indication, if any: _____
6. Please specify any agents and/or treatments (e.g., radiation) that the patient will use in combination with the requested agent, if any: _____
7. Please specify all previous agents and/or treatments (e.g., radiation) that the patient has used for the requested indication, if any: _____

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8. Please list all reasons for selecting the requested agent, 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). **Please note, documentation may be required:** _____

9. Does therapy with the requested agent require specific genetic/diagnostic testing per FDA labeling or compendia (NCCN 1, 2A, or 2B recommended use, AHFS, DrugDex level of evidence of 1, 2A, or 2B, Clinical Pharmacology, phase III clinical trials) for the requested indication? Yes No
 If yes, has the specific genetic/diagnostic testing been completed? Yes No
 If yes, do the results of the specific genetic/diagnostic testing indicate therapy with the requested agent is appropriate? Yes No
10. Will the requested agent be used as monotherapy? Yes No
 If yes, is the requested agent supported for use as monotherapy within FDA labeling or compendia (NCCN 1, 2A, or 2B recommended use, AHFS, DrugDex level of evidence of 1, 2A, or 2B, Clinical Pharmacology, phase III clinical trials) for the requested indication?..... Yes No
 If no, will the requested agent be used as combination therapy and supported as combination therapy (including all agents and/or treatments [e.g., radiation]) within FDA labeling or compendia (NCCN 1, 2A, or 2B recommended use, AHFS, DrugDex level of evidence of 1, 2A, or 2B, Clinical Pharmacology, phase III clinical trials) for the requested indication? Yes No
11. Will the requested agent be used as first-line therapy AND is a first-line agent within FDA labeling or compendia (NCCN 1, 2A, or 2B recommended use, AHFS, DrugDex level of evidence of 1, 2A, or 2B, Clinical Pharmacology, phase III clinical trials) for the requested indication? Yes No
 If no, has the patient tried and had an inadequate response to the appropriate number and types of prerequisite agents within FDA labeling or compendia (NCCN 1, 2A, or 2B recommended use, AHFS, DrugDex level of evidence of 1, 2A, or 2B, Clinical Pharmacology, phase III clinical trials) for the requested indication? Yes No
 If no, does the patient have an intolerance or hypersensitivity to the appropriate number and types of prerequisite agents within FDA labeling or compendia (NCCN 1, 2A, or 2B recommended use, AHFS, DrugDex level of evidence of 1, 2A, or 2B, Clinical Pharmacology, phase III clinical trials) for the requested indication? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to ALL of the required prerequisite agents within FDA labeling or compendia (NCCN 1, 2A, or 2B recommended use, AHFS, DrugDex level of evidence of 1, 2A, or 2B, Clinical Pharmacology, phase III clinical trials) for the requested indication?..... Yes No
 If yes, please specify FDA labeled contraindications: _____

12. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? Yes No
13. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required**..... Yes No
14. If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? Yes No
- For Augtyro and Ibtrozi:**
15. Does the patient have metastatic ROS1-positive non-small cell lung cancer (NSCLC)? Yes No
 If yes, please answer the following questions and **submit chart notes** to support the answers.
- Has the patient tried and had an inadequate response to Rozlytrek or Xalkori for the requested indication? Yes No
 - Was Rozlytrek or Xalkori discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
 - Does the patient have an intolerance or hypersensitivity to Rozlytrek or Xalkori for the requested indication? Yes No

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- Does the patient have an FDA labeled contraindication to both Rozlytrek AND Xalkori for the requested indication? Yes No
- Is Rozlytrek or Xalkori expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
- Is Rozlytrek or Xalkori not in the best interest of the patient based on medical necessity? Yes No
- Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as Rozlytrek or Xalkori and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
- Does NCCN specify the plan preferred agents (Rozlytrek and Xalkori) as a preferred regimen for the requested indication? Yes No
 If no, does NCCN specify the requested agent as a preferred regimen for the requested indication? Yes No
- Is there support for the requested agent over the preferred agents (Rozlytrek and Xalkori) for the requested indication? Yes No
 If yes, please provide supporting information: _____

For Bosulif, Danziten, Nilotinib d-tartrate, nilotinib (generic), Tasigna

16. Is the patient a newly diagnosed adult or pediatric patient with Philadelphia chromosome positive chronic myleoid leukemia (Ph+ CML) in chronic phase? Yes No

If yes, please answer the following questions and **submit chart notes** to support the answers.

- Has the patient tried and had an inadequate response to imatinib (generic) or dasatinib (generic) for the requested indication? Yes No
- Was imatinib (generic) or dasatinib (generic) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
- Does the patient have a documented intolerance or hypersensitivity to imatinib (generic) or dasatinib (generic) for the requested indication? Yes No
- Does the patient have an FDA labeled contraindication to both imatinib (generic) AND dasatinib (generic) for the requested indication? Yes No
- Is imatinib (generic) or dasatinib (generic) expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; or cause a significant barrier to the patient's adherence of care; or worsen a comorbid condition; or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or cause an adverse reaction or cause physical or mental harm? Yes No
- Is imatinib (generic) or dasatinib (generic) not in the best interest of the patient based on medical necessity? Yes No
- Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as imatinib (generic) or dasatinib (generic), and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
- Does NCCN specify the plan preferred agents (imatinib (generic) and dasatinib (generic)) as a preferred regimen for the requested indication? Yes No
 If no, does NCCN specify the requested agent as a preferred regimen for the requested indication? Yes No
- Is there support for the requested agent over the preferred agents (imatinib (generic) and dasatinib (generic)) for the requested indication? Yes No
 If yes, please provide supporting information: _____

17. Is the request for Bosulif or Tasigna? Yes No

If yes, has the patient been previously treated with Bosulif OR Tasigna for chronic myleoid leukemia (CML)? Yes No

18. Is the request for Bosulif capsules? Yes No

If yes, please answer the following questions and **submit chart notes** to support the answers.

- Has the patient tried and had an inadequate response to Bosulif oral tablets? Yes No

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- Were Bosulif oral tablets discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
- Does the patient have an intolerance or hypersensitivity to Bosulif oral tablets that is not expected to occur with the requested agent? Yes No
- Does the patient have an FDA labeled contraindication to Bosulif oral tablets that is not expected to occur with the requested agent? Yes No
- Are Bosulif oral tablets expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
- Are Bosulif oral tablets not in the best interest of the patient based on medical necessity..... Yes No
- Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as Bosulif oral tablets and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... Yes No
- Is there support for the use of the capsules over Bosulif tablets (e.g., swallowing difficulties)?..... Yes No
If yes, please provide supporting information: _____

For Ogiveo:

19. Does the patient have desmoid tumors? Yes No

If yes, please answer the following questions and **submit chart notes** to support the answers.

- Has the patient tried and had an inadequate response to sorafenib (generic) for the requested indication? Yes No
- Was sorafenib (generic) discontinued due to lack of efficacy or effectiveness, or diminished effect, or an adverse event? Yes No
- Does the patient have an intolerance or hypersensitivity to sorafenib (generic) for the requested indication? Yes No
- Does the patient have an FDA labeled contraindication to sorafenib (generic) for the requested indication? Yes No
- Is sorafenib (generic) expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; or cause a significant barrier to the patient's adherence of care; or worsen a comorbid condition; or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or cause an adverse reaction or cause physical or mental harm? Yes No
- Is sorafenib (generic) not in the best interest of the patient based on medical necessity?..... Yes No
- Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as sorafenib (generic) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... Yes No
- Does NCCN specify the plan preferred agent (sorafenib (generic) as a preferred regimen for the requested indication? Yes No
If no, does NCCN specify the requested agent as a preferred regimen for the requested indication? Yes No
- Is there support for the requested agent over the preferred agents (sorafenib (generic) for the requested indication? Yes No
If yes, please provide supporting information: _____

For Ibrance:

20. Does the patient have advanced or metastatic breast cancer? Yes No

If yes, please answer the following questions and **submit chart notes** to support the answers.

- Has the patient tried and had an inadequate response to Kisqali, Kisqali Femara Pack, or Verzenio for the requested indication? Yes No
- Was Kisqali, Kisqali Femara Pack, or Verzenio discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

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- Does the patient have an intolerance or hypersensitivity to KISQALI, KISQALI FEMARA PACK, or VERZENIO for the requested indication? Yes No
- Does the patient have an FDA labeled contraindication to KISQALI, KISQALI FEMARA PACK, AND VERZENIO for the requested indication? Yes No
- Is KISQALI, KISQALI FEMARA PACK, or VERZENIO expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; or cause a significant barrier to the patient's adherence of care; or worsen a comorbid condition; or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or cause an adverse reaction or cause physical or mental harm?..... Yes No
- Is KISQALI, KISQALI FEMARA PACK, or VERZENIO not in the best interest of the patient based on medical necessity? Yes No
- Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as KISQALI, KISQALI FEMARA PACK, or VERZENIO and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
- Does NCCN specify the plan preferred agents (KISQALI, KISQALI FEMARA PACK, or VERZENIO) as a preferred regimen for the requested indication? Yes No
 If no, does NCCN specify the requested agent as a preferred regimen for the requested indication? Yes No
- Is there support for the requested agent over the preferred agents (KISQALI, KISQALI FEMARA PACK, or VERZENIO) for the requested indication? Yes No
 If yes, please provide supporting information: _____

For Imbruvica 140 mg tablets or 280 mg tablets:

21. Please answer the following questions and **submit chart notes** to support the answers.

- Has the patient tried and had an inadequate response to Imbruvica 140mg capsules? Yes No
- Were Imbruvica 140 mg capsules discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
- Does the patient have an intolerance or hypersensitivity to Imbruvica 140 mg capsules that is not expected to occur with Imbruvica tablets?..... Yes No
- Does the patient have an FDA labeled contraindication to Imbruvica 140 mg capsules that is not expected to occur with the Imbruvica tablets?..... Yes No
- Are Imbruvica capsules expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm?..... Yes No
- Are Imbruvica capsules not in the best interest of the patient based on medical necessity?..... Yes No
- Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as Imbruvica capsules and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
- Is there support for the use of the requested agent over Imbruvica 140 mg capsules?..... Yes No
 If yes, please provide supporting information: _____

For Imkeldi:

22. Please answer the following questions and **submit chart notes** to support the answers.

- Has the patient tried and had an inadequate response to imatinib tablets? Yes No
- Were imatinib tablets discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... Yes No
- Does the patient have an intolerance or hypersensitivity to imatinib tablets that is not expected to occur with the requested agent?..... Yes No
- Does the patient have an FDA labeled contraindication to imatinib tablets that is not expected to occur with the requested agent?..... Yes No
- Are imatinib tablets not in the best interest of the patient based on medical necessity?..... Yes No

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- Are imatinib tablets expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
- Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as imatinib tablets and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
- Is there support for the use of the requested agent over imatinib tablets (e.g., swallowing difficulties)?... Yes No
If yes, please provide supporting information: _____

For Mekinist oral solution:

23. Please answer the following questions and **submit chart notes** to support the answers.

- Has the patient tried and had an inadequate response to Mekinist oral tablets? Yes No
- Were Mekinist oral tablets discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes 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
- Does the patient have an FDA labeled contraindication to Mekinist oral tablets that is not expected to occur with the requested agent? Yes No
- Are Mekinist oral tablets expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
- Are Mekinist oral tablets not in the best interest of the patient based on medical necessity? Yes No
- Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as Mekinist oral tablets and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
- Is there support for the use of the requested agent over Mekinist oral tablets (e.g., swallowing difficulties)? Yes No
If yes, please provide supporting information: _____

For Zytiga/abiraterone 500 mg:

24. Please answer the following questions and **submit chart notes** to support the answers.

- Has the patient tried and had an inadequate response to generic abiraterone 250 mg tablets? Yes No
- Were generic abiraterone 250 mg tablets discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes 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
- Does the patient have an FDA labeled contraindication to generic abiraterone 250 mg tablets that is not expected to occur with the requested agent? Yes No
- Are generic abiraterone 250 mg tablets expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; or cause a significant barrier to the patient's adherence of care; or worsen a comorbid condition; or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or cause an adverse reaction or cause physical or mental harm? Yes No
- Are generic abiraterone 250 mg tablets not in the best interest of the patient based on medical necessity? Yes No
- Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic abiraterone 250 mg tablets and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
- Is there support for the use of the requested agent over generic abiraterone 250 mg tablets? Yes No
If yes, please provide supporting information: _____

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If the requested agent is ONE of the following brand agents with a generic equivalent, please answer the following questions and submit chart notes to support the answers:

Brand	Generic Equivalent
Afinitor	everolimus
Afinitor Disperz	everolimus
Gleevec	imatinib
Iressa	gefitinib
Nexavar	sorafenib
Phyrago	dasatinib
Revlimid	lenalidomide
Sprycel	dasatinib
Sutent	sunitinib
Tarceva	erlotinib
Targretin	bexarotene
Tykerb	lapatinib
Votrient	pazopanib
Xeloda	capecitabine
Zytiga	abiraterone

25. Has the patient tried and had an inadequate response to the generic equivalent? Yes No
26. Was the generic equivalent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
27. Does the patient have an intolerance or hypersensitivity to the generic equivalent that is not expected to occur with the brand agent? Yes No
28. Does the patient have an FDA labeled contraindication to the generic equivalent that is not expected to occur with the brand agent? Yes No
29. Is the generic equivalent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
30. Is the generic equivalent not in the best interest of the patient based on medical necessity? Yes No
31. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the generic equivalent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
32. Is there support for the use of the requested brand agent over the generic equivalent? Yes No
 If yes, please provide supporting information: _____

For renewal requests:

33. For Vitrakvi, has the patient had clinical benefit (partial response, complete response, or stable disease) with the requested agent? Yes No
 If yes, please specify: _____

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

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