Priority Health

Medicare Part B Oncology Prior Authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Medicare Part B**

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.

General Oncology Drug Request

Member Information

Last Name: _____ First Name: _____

ID #: _____ DOB: _____

Primary Care Physician: _____ Gender assigned at birth: ☐ Male ☐ Female

Provider Information

Requesting Provider: _____ Phone: _____ Fax: _____

Address: _____

NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Drug and Billing Information *(Please fill out the following information)*

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

Drug product: _____ **HCPCS Code:** _____

ICD-10 Code(s): _____

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 Hospital Facility: _____NPI: _____ Fax:_____

☐ Outpatient Infusion Facility: _____NPI: _____ Fax:_____

☐ Home Infusion Facility: _____NPI: _____ Fax:_____

☐ Other (specify): _____

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Patient to acquire from pharmacy

☐ Physician to acquire from specialty pharmacy and specialty pharmacy to bill:

Specialty Pharmacy: _____ NPI: _____ Fax:_____

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

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Precertification Requirements

Before this drug is covered, the patient must meet the following**:**

1. Must follow applicable NCD and/or LCD, including any documentation (medical record) requirements – AND –

2. Must meet additional Priority Health coverage criteria, if applicable. Not all drugs have additional coverage criteria. Refer to the Medical Benefit Drug List (MBDL) to determine if the requested drug has additional coverage criteria.

    - *When NCD, LCD, or other coverage criteria and benefit conditions included in Traditional Medicare law do not exist or are not fully established, Priority Health Medicare may create coverage criteria based on CMS-approved compendia and current evidence in widely used treatment guidelines or clinical literature.*

National and Local Coverage Determination/Article Criteria

Priority Health Medicare complies with Medicare national coverage policies, including National Coverage Determinations (NCDs). In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare Administrative Contractor (MAC) based on a Local Coverage Determination (LCD).

MACs are appointed by the Centers for Medicare & Medicaid Services (CMS) for a defined geographic jurisdiction, and LCDs can vary. Use the Medicare Coverage Database (MCD) Search tool to find NCDs and/or LCDs applicable to the requested drug or drug class and jurisdiction: https://www.cms.gov/medicare-coverage-database/search.aspx.

For Michigan:

Jurisdiction	Medicare Administrative Contractor (MAC)
Durable Medical Equipment (DME) MAC - Jurisdiction B	CGS Administrators, LLC
A/B MAC - Jurisdiction 8	Wisconsin Physicians Service Government Health Administrators (WPS-GHA)
Home Health & Services - Jurisdiction 6	National Government Services, Inc (NGS)

Medically accepted indication

A medically accepted indication for a drug used in an anti-cancer regimen is defined in the Medicare Benefit Policy Manual Chapter 15 § 50 as a use that is:

- approved by the Food and Drug Administration (FDA). (That is, the FDA has approved the drug for the diagnosis or condition for which it is being prescribed.)
- –– or –– supported by one of the following references (known as compendia): National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Micromedex DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology, or Lexi-Drugs
- –– *or* –– supported in peer-reviewed medical literature appearing in regular editions of approved publications

Additional Information

1. Approval duration: 1 year.
2. For Part B non-oncology drugs: Refer to the Medicare Medical (Part B) Prior Authorization form and/or MBDL.
3. If there is a conflict between this document and Medicare guidance, Medicare guidance supersedes.

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Priority Health Precertification Documentation

A. Is the drug, including drug regimen, being utilized per the NCCN recommended use?
- ☐ Yes **What NCCN Guidelines were reviewed for the request?** _____
- ☐ No

B. Is the drug, including drug regimen, listed as Category 1 or 2A recommendation in NCCN?
- ☐ Yes
- ☐ No

C. Have you reviewed the Medical Benefit Drug List **(**MBDL**) to see if the drug has step therapy and/or other prior authorization requirements?**
- ☐ Yes. *Continue through questions.*
- ☐ No. Refer to the MBDL to ensure all necessary information is provided to support a timely review.

D. Have medical records supporting the request been provided in line with the NCD and/or LCD?
- ☐ Yes
- ☐ No

Please provide any of the following medical record information that may be relevant to the request:

E. What is the patient's ECOG score? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

F. What is the cancer stage? ☐ 1 ☐ 2 ☐ 3 ☐ 4; T_____ N_____ M_____

G. Is this first, second, or subsequent therapy for the stage? ☐ First ☐ Second ☐ Subsequent

H. List the other treatment tried and failed with the associated outcome (failure, intolerance, etc.)

	Drug / Regimen	Stage of disease	Outcome
☐ Drug 1			
☐ Drug 2			
☐ Drug 3			

I. What condition is this drug being requested for? ***Answer any applicable questions based on condition.***

☐ Bladder Cancer
1. **Is it muscle or non-muscle invasive?** ☐ Muscle ☐ Non-Muscle
2. **Is the patient platinum eligible?** ☐ Yes ☐ No
3. **Is the patient PD-L1 positive?** ☐ Yes ☐ No

☐ Breast cancer
1. **Is it ER and/or PR-positive?** ☐ Yes ☐ No
2. **Is it HER2 negative or positive?** ☐ Negative ☐ Positive
3. **Did patient receive endocrine therapy in the past year?** ☐ Yes ☐ No

☐ Chronic Myeloid Leukemia
1. **Is it chronic, accelerated, or blast phase?** ☐ Chronic ☐ Accelerated ☐ Blast
2. **Is it low, intermediate, or high-risk?** ☐ Low ☐ Intermediate ☐ High
3. **Has the patient tried imatinib?** ☐ Yes ☐ No

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☐ Colon cancer
1. **Is it unresectable?** ☐ Yes ☐ No
2. **Is it KRAS wild type?** ☐ Yes ☐ No
3. **For Erbitux® and Vectibix®, are tumors left-sided?** ☐ Yes ☐ No

☐ Esophageal / esophagogastric junction cancers
1. **What is the histology?** ☐ Squamous ☐ Both ☐ Adenocarcinoma
2. **Is the patient a surgical candidate?** ☐ Yes ☐ No

☐ Gastric cancer

☐ Head and neck cancer
1. **What area is affected?** ☐ Nasopharyngeal ☐ Non-Nasopharyngeal

☐ Hepatocellular carcinoma (HCC)

☐ Malignant melanoma

☐ Non-Hodgkin Lymphomas (B-cell lymphomas)
1. **For MZL, what is the type of lymphoma?** ☐ Gastric ☐ Nongastric ☐ Nodal ☐ Splenic

☐ Non-Small Cell Lung Cancer (NSCLC)
1. **Is the patient PD-L1 positive?** ☐ Yes ☐ No
2. **What is the histology?** ☐ Squamous ☐ Both ☐ Adenocarcinoma
3. **Does patient have an EGFR or ALK mutation?** ☐ Yes ☐ No ☐ Not tested

If not tested, provide rationale as to why: _____

☐ Prostate cancer
1. **Castration-sensitive or castration-resistant disease?** ☐ Sensitive ☐ Resistant
2. **Is it adenocarcinoma?** ☐ Yes ☐ No
3. **For metastatic disease, indicate type of metastases:** ☐ Bone ☐ Visceral
4. **For Provenge® requests:**
   a. **Is the patient's life expectancy > 6 months?** ☐ Yes ☐ No
   b. **Is the condition asymptomatic/minimally symptomatic?** ☐ Yes ☐ No

☐ Rectal cancer

☐ Renal cell carcinoma (RCC)
1. **Is it clear or non-clear cell?** ☐ Clear cell ☐ Non-clear cell

☐ Small Cell Lung cancer
1. **What is the stage of the disease?** ☐ Extensive ☐ Limited

☐ Other: _____

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