ORAL ONCOLOGY
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.
By submitting this form, you attest that all information provided is true and accurate.

PLEASE NOTE: Incomplete forms will be returned for additional information.
To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit www.myprime.com

PATIENT AND INSURANCE INFORMATION **Today's date:** _____

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):
Patient Street Address:	City, State:	ZIP:	Patient Phone:
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

MEDICAL INFORMATION. PLEASE ATTACH ADDITIONAL INFORMATION AS NEEDED.

Patient Diagnosis with ICD-9 Code:	ICD-10 Code:
Medication and Strength Requested:	
Dosing Schedule:	Quantity per Month:

ALL REQUESTS

Please list the medications the patient has previously tried and failed for the treatment of this diagnosis:

_____ Date range: _____ _____ Date range: _____
_____ Date range: _____ _____ Date range: _____
_____ Date range: _____ _____ Date range: _____

Is the patient currently treated with the requested agent? ..... ☐ Yes ☐ No

If applicable for dosing, please provide the patient's weight: _____ ☐ LBS ☐ KGS

If applicable for dosing, please provide the patient's BSA in m^2: _____

Does the requested dose exceed the maximum FDA approved dose and frequency?..... ☐ Yes ☐ No

If yes: Is the dose and frequency for the patient's indication supported by the standard reference compendium (AHFS-DI, NCCN Drugs and Biologics Compendium, Clinical Pharmacology, Lexicomp [Evidence rating A, B or G], Thomson Micromedex DrugDex [Strength of recommendation: Class I (Recommended) or IIa (Recommended, In Most Cases) AND Efficacy: Class I (Effective) or IIa (Evidence favors Efficacy))?..... ☐ Yes ☐ No

If no: Is the dose and frequency for the patient's indication supported by the results of **TWO** or more published clinical studies? [NOTE: dose ranging studies, case reports, posters, and abstracts (including published meeting abstracts) are not accepted as evidence to support use.] ..... ☐ Yes ☐ No

If yes: Please submit full text copies of each article for review.

Please continue to the next page.

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):

Is the request for one of the following Brand name medications: Afinitor, Afinitor Disperz, Gleevec, Sutent, Tarceva, Targretin, Temodar, Tykerb, or Votrient? ☐ Yes ☐ No

If yes: Has the patient tried and had intolerable adverse effects to the generic equivalent product? ☐ Yes ☐ No

If yes: Please provide the specific intolerance to the generic equivalent product: _____

_____

Please provide rationale for use of the requested brand product: _____

_____

Has the prescriber completed a Medwatch reporting form (FDA 3500)? Please refer to the FDA website for more information if needed at - https://www.fda.gov/safety/medical-product-safety-information/forms-reporting-fda ☐ Yes ☐ No

Note: Please provide completed Medwatch reporting form (FDA 3500).

Has the prescriber completed the Naranjo Adverse Drug reaction probability scale? Please note, the probability scale worksheet can be found at - https://assets.guidewell.com/m/2736e82ff52fe22d/original/mcg-naranjo-algorithm.pdf ☐ Yes ☐ No

Note: Please provide completed Naranjo ADR probability scale worksheet.

If currently treated with the requested medication: Did a prior health plan pay for the patient's medication during the 90 days immediately before this request? **Please note, documentation of a health plan paid claim for the medication during the 90 days immediately before the request must be submitted.** ☐ Yes ☐ No

INITIAL REQUESTS

Will the patient be using any other medications in combination with the requested medication for treatment of this diagnosis? ☐ Yes ☐ No

If yes: Please specify: _____

_____

Is the patient diagnosed with a condition that is consistent with an indication listed in the product's FDA approved prescribing information (or package insert)? ☐ Yes ☐ No

If yes: Are additional requirements listed in the "Indications and Usage" section of the FDA approved prescribing information (package insert)? ☐ Yes ☐ No

If yes: Does the patient meet the additional requirements listed in the "Indications and Usage" section of the FDA approved prescribing information (package insert)? ☐ Yes ☐ No

If yes: Please explain: _____

_____

Is the indication AND usage of the requested product recognized in NCCN Drugs and Biologics Compendium as a Category 1 or 2A recommendation? ☐ Yes ☐ No

If no: Is the indication AND usage of the requested product supported by the results of TWO or more published clinical studies? [NOTE: Case reports, posters, and abstracts (including published meeting abstracts) are not accepted as evidence to support for use. Clinical studies must be supportive of use for a similar patient population (e.g., indication, diagnosis, disease severity, genetic or tumor mutations) and for the intended treatment plan, including any concomitant therapy.] ☐ Yes ☐ No

If yes: Please submit full text copies of each article for review.

Is the requested product designated as an orphan drug by the FDA for the requested indication AND the indication is not included in the FDA labeling or NCCN compendium as a 1 or 2A recommendation (i.e., "Designated/Approved", "Designated")? ☐ Yes ☐ No

Please continue to the next page.

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):

Does the requested indication require genetic testing and/or specific diagnostic testing per FDA labeling or NCCN Compendia? ☐ Yes ☐ No

If yes: Has the required genetic testing and/or specific diagnostic testing been completed? ☐ Yes ☐ No

If yes: Do the results of the genetic testing and/or specific diagnostic testing indicate therapy with the requested agent is appropriate? **Please note, documentation must be provided for review.** ☐ Yes ☐ No

RENEWAL REQUESTS

Has the patient been previously approved for the requested agent by Florida Blue, Truli, or another health plan in the past 2 years? ☐ Yes ☐ No

If no: Please also complete the Initial Requests section.

Please indicate:

☐ Date of service (if applicable): (mm/dd/yyyy): _____

☐ Start of treatment: Start date (mm/dd/yyyy): _____

☐ Continuation of therapy: Date of last treatment (mm/dd/yyyy): _____

What is the priority level of this request?

☐ Standard

☐ 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.)

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
FAX: 855.212.8110 PHONE: 888.271.3183