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 covermymeds.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. Please provide the following:
   Patient's weight: _____ (kg) Patient's height: _____ (cm)
2. Is the patient currently being treated with the requested agent? ☐ Yes ☐ No
   If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.** ☐ Yes ☐ No
3. Is the patient currently being treated with the requested agent within the past 180 days? ☐ Yes ☐ No
   If yes, is the patient at risk if therapy is changed? ☐ Yes ☐ No
   If yes, please specify risk: _____
   _____
4. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindications: _____
   _____
5. Does the patient have any FDA labeled limitations of use, that are otherwise not supported in National Comprehensive Cancer Network (NCCN), for the requested agent? ☐ Yes ☐ No
   If yes, please specify limitations: _____
   _____
6. Is the patient's age within FDA labeling for the requested indication for the requested agent? ☐ Yes ☐ No
   If no, please provide support for using the requested agent for the patient's age for the requested indication: _____
   _____
7. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, 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:** _____
   _____
   _____

Please continue to the next page.

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

8. Does the requested indication 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 agent? ☐ Yes ☐ No
   If yes, has the specific genetic/diagnostic testing been completed? ☐ Yes ☐ No
      If yes, do results of the specific genetic/diagnostic testing indicate therapy with the requested agent is appropriate? ☐ Yes ☐ No
         If yes, please specify: _____
         _____
9. Will the requested agent be used as monotherapy? ☐ Yes ☐ No
   If yes, is the requested agent approved 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 with all agents and/or treatments (e.g., radiation) AND is approved for use as combination therapy with all agents and/or treatments 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 agents/treatments that will be used in combination therapy: _____
      _____
10. Will the requested agent be used as first-line therapy? ☐ Yes ☐ No
    If yes, the requested agent 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
11. 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 yes, please specify: _____
    If no, does the patient have 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 contraindication: _____
          _____
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

Please continue to the next page.

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

If the request is for Ibrance for advanced or metastatic breast cancer, please submit chart notes to support the answers to the following questions:

15. Has the patient tried and had an inadequate response to Kisqali, Kisqali Femara Pack, or Verzenio? ☐ Yes ☐ No
16. Was Kisqali, Kisqali Femara Pack, or Verzenio discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
17. Does the patient have an intolerance or hypersensitivity to Kisqali, Kisqali Femara Pack, or Verzenio? ☐ Yes ☐ No
18. Does the patient have any FDA labeled contraindications to Kisqali, Kisqali Femara Pack, AND Verzenio? ☐ Yes ☐ No
19. 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
20. Is Kisqali, Kisqali Femara Pack, or Verzenio not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
21. 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
22. Does NCCN specify Kisqali, Kisqali Femara Pack, or Verzenio as a preferred regimen for the requested indication? ☐ Yes ☐ No
23. Does NCCN specify the requested agent is a preferred regimen for the requested indication? ☐ Yes ☐ No
24. Is there support for the requested agent over Kisqali, Kisqali Femara Pack, or Verzenio for the requested indication? ☐ Yes ☐ No

    If yes, please provide supporting information: _____

    _____

If the request is for Imbruvica 140 mg tablets or 280 mg tablets, please submit chart notes to support the answers to the following questions:

25. Has the patient tried and had an inadequate response to Imbruvica 140 mg capsules? ☐ Yes ☐ No
26. Were Imbruvica 140 mg capsules 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 Imbruvica 140 mg capsules that is not expected to occur with Imbruvica tablets? ☐ Yes ☐ No
28. Does the patient have an FDA labeled contraindication to 140 mg Imbruvica capsules that is not expected to occur with Imbruvica tablets? ☐ Yes ☐ No
29. 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
30. Are Imbruvica capsules 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 Imbruvica capsules and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No

If the requested agent is Zytiga/abiraterone 500 mg, please submit chart notes to support the answers to the following questions:

32. Has the patient tried and had an inadequate response to generic abiraterone 250 mg tablets? ☐ Yes ☐ No
33. Were generic abiraterone 250 mg tablets discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
34. 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
35. 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
36. 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
37. Are generic abiraterone 250 mg tablets not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
38. 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

Please continue to the next page.

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

If the request is for Ogsiveo for Desmoid tumors, please submit chart notes to support the answers to the following questions:

39. Has the patient tried and had an inadequate response to sorafenib (generic)? ☐ Yes ☐ No
40. Was sorafenib (generic) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
41. Does the patient have an intolerance or hypersensitivity to sorafenib (generic)? ☐ Yes ☐ No
42. Does the patient have an FDA labeled contraindication to sorafenib (generic)? ☐ Yes ☐ No
43. 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
44. Is sorafenib (generic) not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
45. 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
46. Does NCCN specify sorafenib (generic) as a preferred regimen for the requested indication? ☐ Yes ☐ No
47. Does NCCN specify the requested agent as a preferred regimen for the requested indication? ☐ Yes ☐ No
48. Is there support for the requested agent over sorafenib (generic) for the requested indication? ☐ Yes ☐ No
    If yes, please provide supporting information: _____
    _____

If the request is for Scemblix for Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase with the T315I mutation, please submit chart notes to support the answers to the following questions:

49. Has the patient tried and had an inadequate response to Iclusig? ☐ Yes ☐ No
50. Was Iclusig discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
51. Does the patient have an intolerance or hypersensitivity to Iclusig? ☐ Yes ☐ No
52. Does the patient have an FDA labeled contraindication to Iclusig? ☐ Yes ☐ No
53. Is Iclusig 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
54. Is Iclusig not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
55. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as Iclusig and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
56. Does NCCN specify Iclusig as a preferred regimen for the requested indication? ☐ Yes ☐ No
57. Does NCCN specify the requested agent as a preferred regimen for the requested indication? ☐ Yes ☐ No
58. Is there support for the requested agent over Iclusig for the requested indication? ☐ Yes ☐ No
    If yes, please provide supporting information: _____
    _____

If the requested agent is Bosulif capsules, please submit chart notes to support the answers to the following questions:

59. Has the patient tried and had an inadequate response to Bosulif oral tablets? ☐ Yes ☐ No
60. Were Bosulif oral tablets discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
61. Does the patient have an intolerance or hypersensitivity to Bosulif oral tablets that is not expected to occur with the requested agent? ☐ Yes ☐ No
62. Does the patient have an FDA labeled contraindication to Bosulif oral tablets that is not expected to occur with the requested agent? ☐ Yes ☐ No
63. 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
64. Are Bosulif oral tablets not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
65. 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
66. Is there support for the requested agent over Bosulif oral tablets (e.g., swallowing difficulties)? ☐ Yes ☐ No
    If yes, please provide supporting information: _____
    _____

Please continue to the next page.

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

If the request is for Bosulif or Tasigna for newly diagnosed adult and pediatric patients with Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase, please submit chart notes to support the answers to the following questions:

67. Is the requested agent being used for chronic myeloid leukemia (CML)? ☐ Yes ☐ No
    If yes, has the patient been previously treated with either Bosulif or Tasigna for the requested indication? ☐ Yes ☐ No
68. Has the patient tried and had an inadequate response to dasatinib (generic) or imatinib (generic)? ☐ Yes ☐ No
69. Was dasatinib (generic) or imatinib (generic) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
70. Does the patient have an intolerance or hypersensitivity to dasatinib (generic) or imatinib (generic)? ☐ Yes ☐ No
71. Does the patient have an FDA labeled contraindication to dasatinib (generic) AND imatinib (generic)? ☐ Yes ☐ No
72. Is dasatinib (generic) or imatinib (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
73. Is dasatinib (generic) or imatinib (generic) not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
74. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as dasatinib (generic) or imatinib (generic), and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
75. Does NCCN specify dasatinib (generic) or imatinib (generic) as a preferred regimen for the requested indication? ☐ Yes ☐ No
76. Does NCCN specify the requested agent as a preferred regimen for the requested indication? ☐ Yes ☐ No
77. Is there support the requested agent over dasatinib (generic) or imatinib (generic) for the requested indication? ☐ Yes ☐ No
    If yes, please provide supporting information: _____
    _____

If the request is for Augtyro for metastatic ROS1-positive non-small cell lung cancer, please submit chart notes to support the answers to the following questions:

78. Has the patient tried and had an inadequate response to Rozlytrek or Xalkori? ☐ Yes ☐ No
79. Was Rozlytrek or Xalkori discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
80. Does the patient have an intolerance or hypersensitivity to Rozlytrek or Xalkori? ☐ Yes ☐ No
81. Does the patient have an FDA labeled contraindication to Rozlytrek AND Xalkori? ☐ Yes ☐ No
82. 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
83. Is Rozlytrek or Xalkori not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
84. 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
85. Does NCCN specify Rozlytrek or Xalkori as a preferred regimen for the requested indication? ☐ Yes ☐ No
86. Does NCCN specify the requested agent as a preferred regimen for the requested indication? ☐ Yes ☐ No
87. Is there support for the requested agent over Rozlytrek or Xalkori for the requested indication? ☐ Yes ☐ No
    If yes, please provide supporting information: _____
    _____

Please continue to the next page.

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

If the requested agent is Mekinist oral solution, please submit chart notes to support the answers to the following questions:

88. Has the patient tried and had an inadequate response to Mekinist oral tablets? ☐ Yes ☐ No
89. Were Mekinist oral tablets discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
90. Does the patient have an intolerance or hypersensitivity to Mekinist oral tablets that is not expected to occur with the requested agent? ☐ Yes ☐ No
91. Does the patient have an FDA labeled contraindication to Mekinist oral tablets that is not expected to occur with the requested agent? ☐ Yes ☐ No
92. 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
93. Are Mekinist oral tablets not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
94. 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
95. Is there support for the requested agent over Mekinist oral tablets (e.g., swallowing difficulties)? ☐ Yes ☐ No
    If yes, please provide supporting information: _____

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

Brand	Generic Equivalent
Afinitor	everolimus
Afinitor Disperz	everolimus
Gleevec	imatinib
Iressa	geftinib
Nexavar	sorafenib tosylate
Sprycel	dasatinib
Sutent	sunitinib
Tarceva	erlotinib
Targretin	bexarotene
Temodar	temozolomide
Tykerb	lapatinib
Votrient	pazopanib
Xeloda	capecitabine
Zytiga	abiraterone

96. Has the patient tried and had an inadequate response to the generic equivalent? ☐ Yes ☐ No
97. Was the generic equivalent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
98. Does the patient have a documented intolerance or hypersensitivity to the generic equivalent that is not expected to occur with the brand agent? ☐ Yes ☐ No
99. Does the patient have an FDA labeled contraindication to the generic equivalent that is not expected to occur with the brand agent? ☐ Yes ☐ No
100. 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
101. Is the generic equivalent not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
102. 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
103. Is there support for the use of the requested brand agent over the generic equivalent? ☐ Yes ☐ No
    If yes, please provide supporting information: _____

Please continue to the next page.

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

For Vitrakvi renewal requests:

104. Has the patient experienced clinical benefit (i.e., 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

Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525