Pemetrexed Products (alimta)

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)* ❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)* ❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____*Route of administration* _____
Dosing frequency _____

What is the ICD-10 code? _____

Clinical Criteria Questions:

1. What is the diagnosis?

❒ Bladder cancer (transitional cell urothelium cancer), *Continue to 2*

❒ Cervical cancer, *Continue to 2*

❒ Epithelial ovarian cancer (including carcinosarcoma [malignant mixed Mullerian tumor], clear cell carcinoma of the ovary, grade 1 endometrioid carcinoma, low-grade serous carcinoma/ovarian borderline epithelial tumor [low malignant potential], or mucinous carcinoma of the ovary), *Continue to 2*

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❒ Fallopian tube cancer, *Continue to 2*

❒ Non-small cell lung cancer (non-squamous histology), including leptomeningeal metastases, *Continue to 2*
❒ Pleural or peritoneal mesothelioma, including pericardial mesothelioma and tunica vaginalis testis mesothelioma, *Continue to 2*

❒ Primary central nervous system (CNS) lymphoma, *Continue to 2*

❒ Primary peritoneal cancer, *Continue to 2*

❒ Thymoma or thymic carcinoma, *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Is this a request for continuation of therapy with the requested medication?
❒ Yes, *Continue to 3*
❒ No, *Continue to 4*

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. What is the diagnosis?

❒ Bladder cancer (transitional cell urothelium cancer), *Continue to 8*

❒ Cervical cancer, *Continue to 13*
❒ Epithelial ovarian cancer (including carcinosarcoma [malignant mixed Mullerian tumor], clear cell carcinoma of the ovary, grade 1 endometrioid carcinoma, low-grade serous carcinoma/ovarian borderline epithelial tumor [low malignant potential], or mucinous carcinoma of the ovary), *Continue to 10*

❒ Fallopian tube cancer, *Continue to 10*

❒ Non-small cell lung cancer (non-squamous histology), including leptomeningeal metastases, *Continue to 5*
❒ Pleural or peritoneal mesothelioma, including pericardial mesothelioma and tunica vaginalis testis mesothelioma, *Continue to 6*

❒ Primary central nervous system (CNS) lymphoma, *Continue to 12*

❒ Primary peritoneal cancer, *Continue to 10*

❒ Thymoma or thymic carcinoma, *Continue to 7*

5. What is the histology for the disease?

❒ Non-squamous histology, *No further questions*

❒ Squamous histology, *No further questions*

6. Will the requested medication be given in any of the following regimens?

❒ As a single agent, *No further questions*

❒ In combination with cisplatin or carboplatin, *No further questions*

❒ In combination with bevacizumab (Avastin) and either cisplatin or carboplatin, *No further questions*

❒ In combination with durvalumab (Imfinzi) and either cisplatin or carboplatin, *No further questions*

❒ Other, please specify. _____, *No further questions*

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org

7. Will the requested medication be given as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

8. What is the clinical setting in which the requested medication will be used?

❒ Locally advanced disease, *Continue to 9*

❒ Metastatic disease, *Continue to 9*

❒ Relapsed disease, *Continue to 9*

❒ Other, please specify. _____, *Continue to 9*

9. Will the requested medication be given as second-line treatment?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

10. What is the clinical setting in which the requested medication will be used?

❒ Persistent disease, *Continue to 11*

❒ Recurrent disease, *Continue to 11*

❒ Other, please specify. _____, *Continue to 11*

11. Will the requested medication be given as single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

12. Will the requested medication be given as single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

13. What is the clinical setting in which the requested medication will be used?

❒ Metastatic disease, *No further questions*

❒ Persistent disease, *No further questions*

❒ Recurrent disease, *No further questions*

❒ Other, please specify. _____, *No further questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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