Aliqopa

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? _____

Criteria Questions:

1. What is the diagnosis?

❒ Follicular lymphoma (FL), *Continue to 2*
❒ Gastric MALT lymphoma (extranodal marginal zone lymphoma of the stomach), *Continue to 2*
❒ Non-gastric MALT lymphoma (extranodal marginal zone lymphoma of nongastric sites), *Continue to 2*
❒ Nodal marginal zone lymphoma, *Continue to 2*
❒ Splenic marginal zone lymphoma, *Continue to 2*
❒ Other, please specify. _____, *Continue to 2*

Send completed form to: Priority Partners Fax: 1-866-212-4756

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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?
❒ Follicular lymphoma (FL), *Continue to 5*
❒ Gastric MALT lymphoma (extranodal marginal zone lymphoma of the stomach), *Continue to 5*
❒ Non-gastric MALT lymphoma (extranodal marginal zone lymphoma of nongastric sites), *Continue to 5*
❒ Nodal marginal zone lymphoma, *Continue to 7*
❒ Splenic marginal zone lymphoma, *Continue to 7*

5. What is the place in therapy in which the requested medication will be used?
❒ First-line therapy, *Continue to 6*
❒ Subsequent therapy, *Continue to 6*

6. Has the patient received at least two prior therapies?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

7. What is the place in therapy in which the requested medication will be used?
❒ First-line therapy, *Continue to 8*
❒ Subsequent therapy, *Continue to 8*

8. Has the patient received at least two prior therapies?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

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