

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 ID:	Patient's Name:	Date:
Physician S Name: Specialty: Physician Office Telephone: Physician Office Telephone: Physician Office Fax: Referring Provider Info: Same as Requesting Provider Name: Pfax: Phone: Rendering Provider Info: Same as Referring Provider Name: Phone: Rendering Provider Info: Same as Referring Provider Name: 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: Patient Weight: Patient Height: Com Please indicate the place of service for the requested drug: Ambulatory Surgical (POS Code 24) Office (POS Code 11) Drug Information: Strength/Measure Obirections(sig) Dosing frequency What is the ICD-10 code? Criteria Questions: 1. What is the diagnosis? Glicular lymphoma (FL), Continue to 2 Glicular 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	Patient's ID:	
Physician Office Telephone: Physician Office Fax:	Physician's Name:	
Referring Provider Info: Same as Requesting Provider Name: Phone: Phone	Specialty:	
Name:	Physician Office Telephone:	Physician Office Fax:
Fax: Phone:		
Rendering Provider Info: Same as Referring Provider Same as Requesting Provider NPI#:		
Fax:	Rendering Provider Info: ☐ Same as Referring Provider	r □ Same as Requesting Provider
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:kg Patient H		Phone:
Patient Weight:kg Patient Height:kg Patient Height:kg Patient Height:kg Please indicate the place of service for the requested drug: Ambulatory Surgical (POS Code 24)	accepted compendia, and/or evi	
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□ Ambulatory Surgical (POS Code 24) □ Off Campus Outpatient Hospital (POS Code 19) □ Offfice (POS Code 11) Drug Information: Strength/Measure	Patient Height:cm	
Strength/Measure	☐ Ambulatory Surgical (POS Code 24) ☐ Off Campus Outpatient Hospital (POS Code 19)	☐ Home (POS Code 12) ☐ On Campus Outpatient Hospital (POS Code 22)
Directions(sig)	Drug Information:	
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		Units □ ml □ Gm □ mg □ ea □ Un
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	Directions(sig)	Route of administration
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	Dosing frequency	
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	What is the ICD-10 code?	
☐ 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	Criteria Questions:	
☐ Gastric MALT lymphoma (extranodal marginal zone lymphoma of the stomach), <i>Continue to 2</i> ☐ Non-gastric MALT lymphoma (extranodal marginal zone lymphoma of nongastric sites), <i>Continue to 2</i> ☐ Nodal marginal zone lymphoma, <i>Continue to 2</i> ☐ Splenic marginal zone lymphoma, <i>Continue to 2</i>	1. What is the diagnosis?	
 □ 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 	☐ Follicular lymphoma (FL), 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 	☐ Gastric MALT lymphoma (extranodal marginal zone ly	ymphoma of the stomach), Continue to 2
☐ Nodal marginal zone lymphoma, <i>Continue to 2</i> ☐ Splenic marginal zone lymphoma, <i>Continue to 2</i>		•
☐ Splenic marginal zone lymphoma, <i>Continue to 2</i>		
Other please specify Continue to 2	Other, please specify	Continue to ?

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

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Prescriber or Authorized Signature	Date (mm/dd/yy)
X	
I attest that this information is accurate and true, and that documentation is available for review if requested by Priority Partners.	on supporting this
□ No, No Further Questions	
9. Will the requested medication be used as a single agent? ☐ Yes, <i>No Further Questions</i>	
 8. Has the patient received at least two prior therapies? ☐ Yes, Continue to 9 ☐ No, Continue to 9 	
☐ Subsequent therapy, <i>Continue to 8</i>	
7. What is the place in therapy in which the requested medication will be First-line therapy, <i>Continue to 8</i>	e used?
 6. Has the patient received at least two prior therapies? ☐ Yes, No Further Questions ☐ No, No Further Questions 	
☐ Subsequent therapy, Continue to 6	
5. What is the place in therapy in which the requested medication will be ☐ First-line therapy, <i>Continue to 6</i>	e used?
☐ Splenic marginal zone lymphoma, <i>Continue to 7</i>	
☐ Non-gastric MALT lymphoma (extranodal marginal zone lymphoma ☐ Nodal marginal zone lymphoma, <i>Continue to 7</i>	of nongastric sites), Continue to 5
☐ Gastric MALT lymphoma (extranodal marginal zone lymphoma of th	
4. What is the diagnosis? ☐ Follicular lymphoma (FL), <i>Continue to 5</i>	
3. Is there evidence of unacceptable toxicity or disease progression while ☐ Yes, <i>No Further Questions</i> ☐ No, <i>No Further Questions</i>	e on the current regimen?
☐ Yes, Continue to 3 ☐ No, Continue to 4	

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