Besponsa

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 ______________________________

Criteria Questions:

1. What is the diagnosis?

❒ Acute lymphoblastic leukemia (ALL), *Continue to 2*

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

2. Is the patient currently receiving treatment with the requested drug?

❒ Yes, *Continue to 3*

❒ No, *Continue to 5*

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Besponsa SGM 2261-A – 10/2023.

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. How many cycles of the requested drug has the patient received?
__________ cycles, *No further questions*

5. Does the patient have B-cell precursor acute lymphoblastic leukemia (ALL)?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Is the tumor CD22-positive as confirmed by testing or analysis to identify the CD22 protein on the surface of the B-cell? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming CD22 protein on the surface of the B-cell.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 7*
❒ No, *Continue to 7*
❒ Unknown, *Continue to 7*

7. Will the patient receive more than 6 treatment cycles of the requested drug?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. What is the clinical setting in which the requested drug will be used?
❒ Relapsed disease, *Continue to 9*
❒ Refractory disease, *Continue to 9*
❒ As frontline (induction) therapy, *Continue to 12*
❒ Other, please specify. ________________________, *No further questions*

9. What is the Philadelphia chromosome status of the patient's disease?
❒ Philadelphia chromosome-positive disease, *Continue to 10*
❒ Philadelphia chromosome-negative disease, *Continue to 11*
❒ Unknown, *No further questions*

10. What is the requested regimen?
❒ The requested drug will be used as a single agent, *No further questions*
❒ The requested drug will be used in combination with cyclophosphamide, dexamethasone, vincristine, methotrexate, and cytarabine with or without blinatumomab, *No further questions*
❒ The requested drug will be used in combination with a tyrosine kinase inhibitor (e.g., imatinib, dasatinib, nilotinib, bosutinib, ponatinib), *No further questions*
❒ Other, please specify. ____, *No further questions*

11. What is the requested regimen?

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

❒ The requested drug will be used as a single agent, *No further questions*
❒ The requested drug will be used in combination with cyclophosphamide, dexamethasone, vincristine, methotrexate, and cytarabine with or without blinatumomab, *No further questions*

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

12. What is the Philadelphia chromosome status of the patient's disease?

❒ Philadelphia chromosome-positive disease, *Continue to 13*

❒ Philadelphia chromosome-negative disease, *Continue to 13*

13. What is the requested regimen?
❒ In combination with cyclophosphamide, dexamethasone, vincristine, methotrexate and cytarabine, *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 CVS Caremark or the benefit plan sponsor.

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

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