Cosela

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* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:
Strength/Measure _______________________________*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _________________________________*Route of administration* ________________________
Dosing frequency ______________________________

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. JHHC Cosela SGM 4528-A - 07/2023.

Criteria Questions:

What is the ICD-10 code? __________

1. What is the diagnosis?

❒ Extensive-stage small cell lung cancer (ES-SCLC) (*If checked, go to 2*)
❒ Other, please specify. _________________________ (*If checked, go to 2*)

2. Is the patient 18 years of age or older?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Is the requested medication being used to decrease the incidence of chemotherapy-induced myelosuppression?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Please indicate which of the following chemotherapeutic regimens the patient is receiving:

❒ A platinum/etoposide-containing regimen (*If checked, go to 5*)
❒ A topotecan-containing regimen (*If checked, go to 5*)
❒ Other, please specify. _________________________ (*If checked, go to 5*)

5. Will the requested medication be given within 4 hours prior to the start of chemotherapy on each day chemotherapy is administered?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Will the requested medication be used with a granulocyte colony-stimulating factor (G-CSF) as primary prophylaxis during cycle 1?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Will the requested medication be used with an erythropoiesis-stimulating agent (ESA) as primary prophylaxis during cycle 1?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Is this request for initiation or continuation of therapy?

❒ Initiation of therapy (*If checked, no further questions*)
❒ Continuation of therapy (*If checked, 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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