JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Faslodex [fulvestrant]

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 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

Criteria Questions:

1. Which drug is being prescribed? ❑ Faslodex ❑ fulvestrant

2. What is the diagnosis?
   ❑ Breast cancer
   ❑ Endometrial carcinoma
   ❑ Uterine sarcoma
   ❑ Low grade serous ovarian carcinoma
   ❑ Other _____

2. What is the ICD-10 code? _____

3. Is the patient currently receiving treatment with the requested medication?
   ❑ Yes ❑ No *If No, skip to diagnosis section*

4. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Breast Cancer

5. Does the patient have recurrent, advanced, or metastatic breast cancer? ❑ Yes ❑ No

6. What is the patient's hormone receptor (HR) status? ***ACTION REQUIRED: Please attach documentation of hormone receptor (HR) status.*** ❑ Positive ❑ Negative ❑ Unknown

Section B: Low Grade Serous Ovarian Carcinoma

7. Does that patient have recurrent or persistent disease? ❑ Yes ❑ No

8. Will the requested medication be used as a single agent? ❑ Yes ❑ No

Section C: Endometrial Carcinoma

9. Will the requested medication be used as a single agent? ❑ Yes ❑ No

Section D: Uterine Sarcoma

10. Does the patient have low-grade endometrial stromal sarcoma, adenosarcoma without sarcomatous overgrowth, or estrogen receptor/ progesterone receptor positive (ER/PR+) uterine sarcoma?
    ❑ Yes, low-grade endometrial stroma sarcoma
    ❑ Yes, adenosarcoma without sarcomatous overgrowth
    ❑ Yes, ER/PR+ uterine sarcoma
    ❑ No

11. Will the medication be used as a single agent? ❑ Yes ❑ No

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)**

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

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
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