Pralatrexate-Folotyn

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 (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. Is this a request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 2*
❒ No, *Continue to 4*

2. What is the diagnosis?
❒ Peripheral T-cell lymphoma (PTCL) (including the following subtypes: anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with T-follicular helper (TFH) phenotype, or follicular T-cell lymphoma), *Continue to 3*

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❒ Adult T-cell leukemia/lymphoma (ATLL), *Continue to 3*

❒ Mycosis fungoides (MF), *Continue to 3*

❒ Sezary syndrome (SS), *Continue to 3*

❒ Cutaneous anaplastic large cell lymphoma (ALCL), *Continue to 3*

❒ Extranodal NK/T-cell lymphoma, *Continue to 3*

❒ Hepatosplenic T-cell lymphoma, *Continue to 3*

❒ Breast implant-associated anaplastic large cell lymphoma (ALCL), *Continue to 3*

❒ Other, please specify. _____, *Continue to 3*

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?
❒ Peripheral T-cell lymphoma (PTCL) (including the following subtypes: anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with T-follicular helper (TFH) phenotype, or follicular T-cell lymphoma), *Continue to 5*

❒ Adult T-cell leukemia/lymphoma (ATLL), *Continue to 7*

❒ Mycosis fungoides (MF), *No further questions*

❒ Sezary syndrome (SS), *No further questions*

❒ Cutaneous anaplastic large cell lymphoma (ALCL), *Continue to 9*

❒ Extranodal NK/T-cell lymphoma, *Continue to 10*

❒ Hepatosplenic T-cell lymphoma, *Continue to 14*

❒ Breast implant-associated anaplastic large cell lymphoma (ALCL), *Continue to 16*

5. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. What is the clinical setting in which the requested drug will be used?

❒ Relapsed disease, *No further questions*

❒ Refractory disease, *No further questions*

❒ The requested drug will be used for initial palliative therapy, *No further questions*

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

7. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. What is the place in therapy in which the requested drug will be used?

❒ First-line therapy, *No further questions*

❒ Subsequent therapy, *No further questions*

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

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

10. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. What is the clinical setting in which the requested drug will be used?

❒ Relapsed disease, *Continue to 12*

❒ Refractory disease, *Continue to 12*

❒ Other, please specify. _____, *Continue to 12*

12. Has the patient had an inadequate response to asparaginase-based therapy (e.g., pegaspargase)?
❒ Yes, *No Further Questions*
❒ No, *Continue to 13*

13. Does the patient have a contraindication to asparaginase-based therapy (e.g., pegaspargase)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

14. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. How many previous lines of chemotherapy has the patient received?

_____,*No further questions*

16. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. What is the place in therapy in which the requested drug will be used?

❒ First-line therapy, *No further questions*

❒ Subsequent therapy, *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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