Imfinzi

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. Has the patient experienced disease progression while on PD-1 or PD-L1 inhibitor therapy (e.g., Opdivo)?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. What is the diagnosis?
❒ Non-small cell lung cancer (NSCLC), *Continue to 3*

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

 Imfinzi SGM 1820-A – 02/2024.

❒ Extensive-stage small cell lung cancer (ES-SCLC), *Continue to 13*

❒ Hepatocellular carcinoma, *Continue to 17*

❒ Biliary tract cancer (gallbladder cancer, intrahepatic/extrahepatic cholangiocarcinoma), *Continue to 22*

❒ Cervical cancer, *Continue to 27*

❒ Ampullary adenocarcinoma, *Continue to 32*

❒ Esophageal, Esophagogastric Junction and Gastric Cancer, *Continue to 38*

❒ Pleural mesothelioma, *Continue to 45*

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

3. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 4*
❒ No, *Continue to 8*

4. Which of the following applies to the patient's disease?

❒ Unresectable stage II or III disease, *Continue to 5*

❒ Recurrent disease, *Continue to 7*

❒ Advanced disease, *Continue to 7*

❒ Metastatic disease, *Continue to 7*

5. How many months of treatment has the patient received?

_____months, *Continue to 6*

6. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

7. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

8. What is the clinical setting in which the requested medication will be used?

❒ Advanced disease, *Continue to 10*

❒ Metastatic disease, *Continue to 10*

❒ Recurrent disease, *Continue to 10*

❒ Unresectable Stage II or Stage III disease, *Continue to 9*

9. Has the disease progressed following concurrent platinum-based chemotherapy (e.g., cisplatin, carboplatin) and radiation therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

10. Will the requested medication be used in combination with tremelimumab-actl (Imjudo) and platinum-based chemotherapy (e.g., cisplatin, carboplatin)?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is the tumor negative for epidermal growth factor receptor (EGFR) exon 19 deletion and L858R mutation and anaplastic lymphoma kinase (ALK) rearrangements? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or test results of the absence of EGFR exon 19 deletion and L858R and ALK rearrangements.

❒ Yes ***ACTION REQUIRED***: *Submit supporting documentation, No further questions*

❒ No, *No further questions*

❒ Unknown, *Continue to 12*

12. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

13. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 14*
❒ No, *Continue to 15*

14. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

15. Will the requested medication be used in combination with etoposide and either carboplatin or cisplatin followed by single agent maintenance?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. What is the place in therapy in which the requested medication will be used?

❒ First-line treatment, *No further questions*

❒ Subsequent treatment, *No further questions*

17. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 18*
❒ No, *Continue to 19*

18. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

19. Will the requested medication be used in any of the following regimens?

❒ Single agent, *Continue to 20*

❒ In combination with tremelimumab-actl (Imjudo), *Continue to 20*

❒ Other, please specify. _____, *Continue to 20*

20. What is the place in therapy in which the requested medication will be used?

❒ First-line treatment, *Continue to 21*

❒ Subsequent treatment, *Continue to 21*

21. What is the clinical setting in which the requested medication will be used?

❒ Unresectable/inoperable disease, *No further questions*

❒ Metastatic disease, *No further questions*

❒ Extensive liver tumor burden disease, *No further questions*

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

22. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to 23*

❒ No, *Continue to 24*

23. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

24. Will the requested medication be used in combination with cisplatin and gemcitabine?

❒ Yes, *Continue to 25*

❒ No, *Continue to 25*

25. What is the clinical setting in which the requested medication will be used?

❒ Locally advanced disease, *No further questions*

❒ Unresectable disease, *No further questions*

❒ Resected gross residual (R2) disease, *No further questions*

❒ Metastatic disease, *No further questions*

❒ Recurrent disease, *Continue to 26*

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

26. Did the disease recur after surgery and adjuvant therapy?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

27. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to 28*

❒ No, *Continue to 29*

28. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

29. Is the requested medication being used to treat small cell neuroendocrine carcinoma of the cervix (NECC)?
❒ Yes, *Continue to 30*
❒ No, *Continue to 30*

30. Will the requested medication be used in combination with etoposide and either cisplatin or carboplatin?
❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

31. What is the clinical setting in which the requested medication will be used?

❒ Persistent disease, *No further questions*

❒ Recurrent disease, *No further questions*

❒ Metastatic disease, *No further questions*

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

32. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 33*
❒ No, *Continue to 34*

33. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

34. What is the place in therapy in which the requested medication will be used?

❒ First-line treatment, *Continue to 35*

❒ Subsequent treatment, *Continue to 35*

35. What is the clinical setting in which the requested medication will be used?

❒ Unresectable disease, *Continue to 36*

❒ Metastatic disease, *Continue to 36*

❒ Other, please specify. _____, *Continue to 36*

36. What is the disease type?

❒ Pancreatobiliary disease, *Continue to 37*

❒ Mixed type disease, *Continue to 37*

❒ Other, please specify. _____, *Continue to 37*

37. Will the requested medication be used in combination with cisplatin and gemcitabine?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

38. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to 39*
❒ No, *Continue to 41*

39. How many doses has the patient received?

_____doses, *No further questions*

40. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

41. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming microsatellite instability-high or mismatch repair deficient tumor status.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 42*

❒ No, *Continue to 42*

❒ Unknown, *Continue to 42*

42. Will the requested medication be used as neoadjuvant treatment?
❒ Yes, *Continue to 43*
❒ No, *Continue to 43*

43. Will the requested medication be used in combination with tremelimumab (Imjudo)?
❒ Yes, *Continue to 44*
❒ No, *Continue to 44*

44. Is the patient medically fit for surgery?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

45. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 46*
❒ No, *Continue to 47*

46. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

47. What is the clinical setting in which the requested medication will be used?

❒ Unresectable disease, *Continue to 48*

❒ Other, please specify. _____, *Continue to 48*

48. What is the place in therapy in which the requested medication will be used?

❒ First-line treatment, *Continue to 49*

❒ Subsequent treatment, *Continue to 49*

49. Will the requested medication be used in combination with pemetrexed and either cisplatin or carboplatin?
❒ Yes, *No Further Questions*
❒ No, *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)**

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

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