Istodax

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

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

Criteria Questions:

1. What is the diagnosis?

❒ Cutaneous T-cell lymphoma (e.g., mycosis fungoides [MF], Sezary syndrome [SS], primary cutaneous anaplastic large cell lymphoma), *Continue to 2*

❒ Peripheral T-cell lymphoma not otherwise specified (PTCL-NOS), *Continue to 2*

❒ Angioimmunoblastic T-cell lymphoma (AITL), *Continue to 2*

❒ Anaplastic large cell lymphoma (ALCL), *Continue to 2*

❒ Breast implant-associated anaplastic large cell lymphoma (BIA-ALCL), *Continue to 2*

❒ Enteropathy-associated T-cell lymphoma (EATL), *Continue to 2*

❒ Monomorphic epitheliotropic intestinal T-cell lymphoma (MEITL), *Continue to 2*

❒ Nodal peripheral T-cell lymphoma with TFH phenotype (PTCL, TFH), *Continue to 2*

❒ Follicular T-cell lymphoma (FTCL), *Continue to 2*

❒ Extranodal NK/T-cell lymphoma (ENKL), *Continue to 2*

❒ Hepatosplenic T-cell lymphoma (HSTCL), *Continue to 2*

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

2. Is this a request for continuation of therapy with the requested drug?

❒ Yes, *Continue to 3*

❒ No, *No Further Questions*

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

❒ 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)**

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