Padcev

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? _____

Clinical Criteria Questions:

1. What is the diagnosis?

❒ Urothelial carcinoma - Bladder cancer, *Continue to 2*

❒ Urothelial carcinoma - Primary carcinoma of the urethra, *Continue to 2*

❒ Urothelial carcinoma - Upper genitourinary tract tumors, *Continue to 2*

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❒ Urothelial carcinoma - Urothelial carcinoma of the prostate, *Continue to 2*

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

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

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

4. What is the requested regimen?

❒ As a single agent, *Continue to 5*

❒ In combination with pembrolizumab (Keytruda), *Continue to 9*

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

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

❒ First-line treatment, *Continue to 6*

❒ Subsequent treatment, *Continue to 6*

6. Is the patient ineligible for cisplatin-containing chemotherapy?
❒ Yes, *Continue to 10*
❒ No, *Continue to 7*

7. Has the patient received prior treatment with a platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Has the patient received prior treatment with a programmed death receptor-1 (PD-1) (e.g., Keytruda, Opdivo) or programmed death-ligand (PD-L1) inhibitor (e.g., Bavencio, Tecentriq)?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

9. Is the patient ineligible for cisplatin-containing chemotherapy?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. What is the diagnosis?

❒ Urothelial carcinoma - Bladder cancer, *Continue to 11*

❒ Urothelial carcinoma - Primary carcinoma of the urethra, *Continue to 14*

❒ Urothelial carcinoma - Upper genitourinary tract tumors, *Continue to 15*

❒ Urothelial carcinoma - Urothelial carcinoma of the prostate, *Continue to 15*

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Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org.

11. Will the drug be used for either of the following: a) Metastatic or local recurrence post-cystectomy or b) Muscle invasive local recurrence or persistent disease in a preserved bladder?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. What is the clinical setting in which the requested drug will be used?
❒ Locally advanced disease, *No further questions*
❒ Metastatic disease, *No further questions*
❒ Stage II disease, *Continue to 13*
❒ Other, please specify. _____, *Continue to 13*

13. Is the tumor present following reassessment of tumor status 2-3 months after primary treatment with concurrent bladder preserving chemoradiotherapy, and maximal transurethral resection of bladder tumor (TURBT)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

14. What is the clinical setting in which the requested drug will be used?
❒ Recurrent disease, *No further questions*
❒ Locally advanced disease, *No further questions*
❒ Metastatic disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

15. What is the clinical setting in which the requested drug will be used?
❒ Locally advanced disease, *No further questions*
❒ Metastatic disease, *No further questions*
❒ Other, please specify. _____, *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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