JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTHCARE

# Torisel (temsirolimus)

## 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* ❑ *Pharmacy*

**Drug Information:**

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

**Criteria Questions:**

1. What drug is being prescribed? ❑ Torisel ❑ temsirolimus
2. What is the patient's diagnosis?
   - ❑ Renal cell carcinoma
   - ❑ Endometrial carcinoma
   - ❑ Soft tissue sarcoma (STS)
   - ❑ Mantle cell lymphoma
   - ❑ Other _____

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

 Torisel [temsirolimus] SGM 2081-A – 12/2022.

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

3. What is the ICD-10 code? _____

4. Is this request for continuation of therapy with the requested medication?
   ❑ Yes ❑ No *If No, skip to diagnosis section*

5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions*

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

Section A: Endometrial Carcinoma

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

Section B: Soft Tissue Sarcoma

7. What is the soft tissue sarcoma (STS) subtype?
   ❑ Perivascular epithelioid cell tumor (PEComa), *Skip to #9*
   ❑ Recurrent angiomyolipoma
   ❑ Lymphangioleiomyomatosis
   ❑ Rhabdomyosarcoma, *Skip to #11*
   ❑ Other _____

8. What is the clinical setting in which the requested medication will be used?
   ❑ Recurrent disease ❑ Other *Any answer, skip to #10*

9. What is the clinical setting in which the requested medication will be used?
   ❑ Locally advanced unresectable disease
   ❑ Metastatic disease
   ❑ Other

10. Will requested drug be used as a single agent? ❑ Yes ❑ No *No further questions*

11. Will the requested medication be used in combination with cyclophosphamide and vinorelbine?
    ❑ Yes ❑ No

Section C: Renal Cell Carcinoma

12. What is the clinical setting in which the requested medication will be used?
    ❑ Advanced disease
    ❑ Relapsed disease
    ❑ Stage IV disease
    ❑ Other _____

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

Section D: Mantle cell lymphoma

14. What is the clinical setting in which the requested medication will be used?
    ❑ Relapsed disease
    ❑ Refractory disease
    ❑ Other _____

***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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