Velcade (bortezomib)

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:** ____________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

<u>Rendering</u> 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.

<u>Required Demographic Information:</u>

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*

<u>Drug Information:</u>

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Velcade (Bortezomib) SGM 2233-C – 04/2023.

Criteria Questions:

What is the ICD-10 code? __________

1. What is the patient's diagnosis?

❒ Multiple myeloma, *Continue to #2*

❒ Mantle cell lymphoma, *Continue to #2*

❒ Multicentric Castleman disease, *Continue to #2*

❒ Systemic light chain amyloidosis, *Continue to #2*

❒ Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, *Continue to #2*

❒ Adult T-cell leukemia/lymphoma, *Continue to #2*

❒ Antibody mediated rejection of solid organ, *Continue to #2*

❒ Acute lymphoblastic leukemia, *Continue to #2*

❒ Follicular lymphoma, *Continue to #2*

❒ Kaposi sarcoma, *Continue to #2*

❒ Classic Hodgkin Lymphoma, *Continue to #2*

❒ POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome, *Continue to #2*

❒ Other, *Continue to #2*

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

❒ Yes, *Continue to #3*

❒ No, *Continue to #4*

3. Has the patient experienced unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *Continue to #200*

❒ No, *Continue to #200*

4. What is the patient's diagnosis?

❒ Multiple myeloma, *Continue to #200*

❒ Mantle cell lymphoma, *Continue to #200*

❒ Multicentric Castleman disease, *Continue to #10*

❒ Systemic light chain amyloidosis, *Continue to #200*

❒ Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, *Continue to #200*

❒ Adult T-cell leukemia/lymphoma, *Continue to #40*

❒ Antibody mediated rejection of solid organ, *Continue to #200*

❒ Acute lymphoblastic leukemia, *Continue to #50*

❒ Follicular lymphoma, *Continue to #60*

❒ Kaposi sarcoma, *Continue to #70*

❒ Classic Hodgkin Lymphoma, *Continue to #80*

❒ POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome, *Continue to #90*

Multicentric Castleman disease

10. What is the place in therapy in which the requested medication will be used?
❒ First line therapy, *Continue to #200*
❒ Subsequent therapy, *Continue to #200*

Adult T-cell leukemia/lymphoma

40. Will the requested medication be used as a single agent?
❒ Yes, *Continue to #41*
❒ No, *Continue to #41*

41. What is the place in therapy in which the requested medication will be used?
❒ First line therapy, *Continue to #200*
❒ Subsequent therapy, *Continue to #200*

Acute lymphoblastic leukemia

50. What is the clinical setting in which the requested medication will be used?
❒ Relapsed disease, *Continue to #200*
❒ Refractory disease, *Continue to #200*
❒ Other, *Continue to #200*

Follicular lymphoma

60. What is the clinical setting in which the requested medication will be used?
❒ Relapsed disease, *Continue to #200*
❒ Refractory disease, *Continue to #200*
❒ Other, *Continue to #200*

Kaposi sarcoma

70. What is the place in therapy in which the requested medication will be used?
❒ First line therapy, *Continue to #200*
❒ Subsequent therapy, *Continue to #200*

Classic Hodgkin Lymphoma

80. What is the clinical setting in which the requested medication will be used?
❒ Relapsed disease, *Continue to #200*
❒ Refractory disease, *Continue to #200*
❒ Other, *Continue to #200*

POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome

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90. Will the requested medication be used in combination with dexamethasone?
❒ Yes, *Continue to #200*
❒ No, *Continue to #200*

Dosage and Administration

200. What is the patient's height in inches? _____________ (Fill-in-the blank)
❒ Any answer, *Continue to #201*

201. What is the patient's weight in pounds? ______________ (Fill-in-the-blank)
❒ Any answer, *Continue to #202*

202. What is the patient's Body Surface Area (BSA)? (Note average adult BSA is around 1.7 m2) ______________ (Fill-in-the-blank)
❒ Any answer, *Continue to #203*

203. What is the patient's dose in milligrams? ____________________ (Fill-in-the-blank)
❒ Any answer, *Continue to #204*

204. Will the patient's dose exceed 1.6 mg/m2? (Pharmacist/NLX to calculate dose from responses to questions #200 to 203)
❒ Yes, *Continue to #205*
❒ No, *Continue to #205*

205. Does the member require more than 7 doses per 30 day period?
❒ 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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Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076

Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com