Zaltrap

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 (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)*

<u>Drug Information:</u>

*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

*Directions(sig)*_________________________________ *Route of administration*________________________

*Dosing frequency*______________________________

What is the ICD-10 code? _____________

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. Zaltrap SGM 1667-A – 01/2024.

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076

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

Criteria Questions:

1. What is the diagnosis?

❒ Colorectal cancer (CRC), including anal adenocarcinoma and appendiceal adenocarcinoma, *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. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

❒ Advanced disease, *Continue to 5*

❒ Metastatic disease, *Continue to 5*

❒ Other, please specify. _________________________, *Continue to 5*

5. What will be the prescribed regimen?

❒ The requested medication in combination with 5-fluorouracil, leucovorin, and irinotecan (FOLFIRI), *No further questions*

❒ The requested medication in combination with irinotecan, *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 Priority Partners.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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