Zepzelca

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? _____

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.hopkinshealthplans.org

Criteria Questions:

1. What is the diagnosis?

❒ Small cell lung cancer, *Continue to 2*

❒ Other, *No further questions*

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

3. Is there evidence of unacceptable toxicity or disease progression 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?

❒ Metastatic disease, *Continue to 6*

❒ Primary progressive disease, *Continue to 7*

❒ Relapsed disease, *Continue to 5*

❒ Other, please specify. _____, *Continue to 7*

5. Will the requested medication be used for relapse following complete or partial response or stable disease with initial treatment?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

6. Has the patient experienced disease progression on or after platinum-based chemotherapy?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

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

❒ First-line treatment, *Continue to 8*

❒ Subsequent treatment, *Continue to 8*

8. Will the requested medication be given as a single agent?
❒ 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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