Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Oral Oncology Agents

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. The request is for initial approval. If YES, go to 2. If NO, go to 13.

☐ Yes ☐ No

Q2. The requested drug is being prescribed to treat a patient with stage IV advanced, metastatic cancer with its use being consistent for an FDA-approved indication, the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium indication for the treatment of stage IV advanced, metastatic cancer, and/or is supported by peer-reviewed medical literature. If NO, go to 3.

☐ Yes ☐ No

Q3. The patient is prescribed the Oral Oncology Agent for the treatment of a diagnosis that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication OR an indication supported by NCCN guidelines. If YES, go to 4.

☐ Yes ☐ No

Q4. The patient is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature. If YES, go to 5.

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q5. The patient is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature. If YES, go to 6.

☐ Yes ☐ No

Q6. The drug is being prescribed by or in consultation with an oncologist or hematologist. If YES, go to 7.

☐ Yes ☐ No

Q7. The patient has a current history (within the past 180 days) of being prescribed the same Oral Oncology Agent. If NO, go to 8.

☐ Yes ☐ No

Q8. For a non-formulary Oral Oncology Agent with a therapeutically equivalent brand or generic that is included on the formulary, has ONE of the following: If YES or NA, go to 9.

☐ The patient has an intolerance or hypersensitivity to the therapeutically equivalent drug that is not expected to occur with the non-formulary drug OR

☐ The patient has an FDA labeled contraindication to the therapeutically equivalent drug that is not expected to occur with the non-formulary drug (medical records required) OR

☐ There is support for the use of the non-formulary drug over the therapeutically equivalent formulary drug (medical records required)

Q9. The requested indication requires specific genetic/diagnostic testing per FDA labeling or compendia for the requested agent. If YES, go to 10. If NO, go to 11.

☐ Yes ☐ No

Q10. Specific genetic/diagnostic testing has been completed AND the results of the specific genetic/diagnostic testing indicate therapy with the requested agent is appropriate (medical records required). If YES, go to 11.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q11. ONE of the following: If YES, go to 12.

☐ The requested agent will be used as monotherapy AND is approved for use as monotherapy within FDA labeling or compendia for the requested indication OR

☐ The requested agent will be used as combination therapy with all agents and/or treatments (e.g., radiation) AND is approved for use as combination therapy with all agents and/or treatments within FDA labeling or compendia for the requested indication

Q12. ONE of the following:

☐ The requested agent will be used as first-line therapy AND is a first-line agent within FDA labeling or compendia for the requested indication OR

☐ The patient has tried and had an inadequate response to the appropriate number and types of prerequisite agents within FDA labeling or compendia for the requested indication OR

☐ The patient has an intolerance or hypersensitivity to the appropriate number and types of prerequisite agents within the FDA labeling or compendia for the requested indication OR

☐ The patient has an FDA labeled contraindication to ALL of the required prerequisite agent(s) listed in the FDA labeling or compendia for the requested indication.

Q13. Documentation is provided that the patient has a positive clinical response to the drug. If YES, go to 14.

☐ Yes ☐ No

Q14. The patient is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature. If YES, go to 15.

☐ Yes ☐ No

Q15. The drug is being prescribed by or in consultation with an oncologist or hematologist.

☐ Yes ☐ No

Q16. Additional Information:

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Patient Name:	**Prescriber Name:**

_____ _____

Prescriber Signature Date

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