HIGHMARK WHOLECARE

Updated: 3/2024
PARP Approved: 4/2024

Prior Authorization Criteria

Oncology Medications, IV/Injectable

All requests for IV/Injectable Oncology Medications (excluding biosimilars) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

This policy applies to every IV/Injectable oncology product that does not have its own specific policy

For all requests for IV/Injectable oncology medications, all of the following criteria must be met:

- The member has a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package insert, listed in nationally recognized compendia, or peer reviewed medical literature for the determination of medically-accepted indications
- If not indicated as a first line agent, either in the FDA approved package insert, nationally recognized compendia, or peer reviewed medical literature, must provide documentation of previous therapies tried and failed (previous therapies must include those recommended by the FDA approved package insert, nationally recognized compendia, or peer reviewed medical literature)
- Prescribed by, or in consultation with, an oncologist or hematologist
- Unless indicated as monotherapy, must be used in combination with other chemotherapeutic or adjuvant agents according to the FDA approved prescribing information, nationally recognized compendia, or peer reviewed medical literature
- If a test with adequate ability to confirm a disease mutation exists, documentation that the test was performed to confirm the mutation
- The member does not have any contraindications to the requested medication
- Must have a therapeutic failure, contraindication, or intolerance to the biosimilar agent(s) approved or medically accepted for the member's diagnosis
- For requests to start a new non-formulary agent, must have a therapeutic failure, contraindication, or intolerance to the formulary agent(s) approved or medically accepted for the member's diagnosis
- The prescribed quantity and dosing regimen is in accordance with the manufacturer's published dosing guidelines, nationally recognized compendia, or peer reviewed medical literature
- **Initial Duration of Approval:** as requested with a maximum of 12 months
- **Reauthorization criteria:**
    - Documentation that the member had a positive clinical response to therapy
- **Reauthorization Duration of Approval:** as requested with a maximum of 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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Need to submit a request quickly? Visit our web portal at oneum.oncohealth.us

Chemotherapy and Supportive Care Prior Authorization Request Form

REQUEST DATE: _____ **TREATMENT START DATE: _____**

PLEASE SUBMIT PROGRESS NOTES, COMPLETE CHEMO ORDERS, LABS, PATHOLOGY AND IMAGING RESULTS WITH REQUEST

☐ **Standard**
☐ **Urgent**

I. MEMBER INFORMATION

First:	Last:	DOB:	☐ Male ☐ Female
Height:	Weight:	BSA (m^2):	
Diagnosis:	ICD-10:	Stage (0-4):	
Insurance:	Line of Business (e.g., Medicare):	Member ID:	

II. ANTI-CANCER TREATMENT AND SUPPORTIVE DRUG REQUEST

#	Billing Code	Drug Name	Route	Dose	Frequency & Schedule	Indication	Is the patient currently being treated with this regimen? (Y=Yes, N= No)	Request Brand Name	Billing Method (B = Buy & Bill or P = Pharmacy)	If applicable, Do you agree to opt-in to vial rounding? (Y=Yes, N= No)
Please list ALL components of the ENTIRE regimen, including oral and PA Exempt drugs										
1.							☐ Y ☐ N	☐ Brand	☐ B ☐ P	☐ Y ☐ N
2.							☐ Y ☐ N	☐ Brand	☐ B ☐ P	☐ Y ☐ N
3.							☐ Y ☐ N	☐ Brand	☐ B ☐ P	☐ Y ☐ N
4.							☐ Y ☐ N	☐ Brand	☐ B ☐ P	☐ Y ☐ N
5.							☐ Y ☐ N	☐ Brand	☐ B ☐ P	☐ Y ☐ N
6.							☐ Y ☐ N	☐ Brand	☐ B ☐ P	☐ Y ☐ N

III. PROVIDER AND PLACE OF TREATMENT INFORMATION

Ordering Provider:	NPI #:	TIN #:
	Phone:	Fax:
Treating Provider: (if different)	NPI #:	TIN #:
Place of Treatment: (if different)	NPI #:	TIN #:
Office Contact:	Phone:	Fax:

IV. PREFERRED PRODUCTS

a. **If applicable**, do you agree to substitution of a Reference product with its FDA-approved Biosimilar product when part of a mandatory Step-Therapy Program*? ☐ Yes ☐ No ☐ Unknown
*Per CMS, mandatory changes to preferred products do **NOT** apply to **Medicare** patients if they have received the Non-Preferred product in the past 365 days.

b. **If yes**, please list preferred Biosimilar product here: (JCode)_____(Name)_____
(For a list of Preferred Products, please see individual Step Therapy Policy, call OncoHealth at (888) 916-2616, or submit request via OH Web Portal at: https://oneum.oncohealth.us)