Gateway Health℠ It's Wholecare.

Updated: 01/2021
PARP Approved: 02/2021

Prior Authorization Criteria

Oncology Medications, IV/Injectable

All requests for IV/Injectable Oncology Medications 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 and is able to tolerate 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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Chemotherapy and Supportive Care Prior Authorization Request Form

REQUEST DATE: _____ TREATMENT START DATE: _____ ☐ Standard ☐ Expedited

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 REQUEST ☐ New ☐ Retrospective ☐ Re-authorization

#	Billing Code	Drug Name	Route	Dose	Frequency & Schedule	Cycles or Refills	Billing Method (B = Buy & Bill or P = Pharmacy)
1							☐ B ☐ P
2							☐ B ☐ P
3							☐ B ☐ P
4							☐ B ☐ P

III. SUPPORTING CARE DRUGS REQUESTED (see attached drug list for reference)

#	Billing Code	Drug Name	Route	Dose	Frequency & Schedule	Condition (e.g. nausea)	Billing Method (B = Buy & Bill or P = Pharmacy)
1							☐ B ☐ P
2							☐ B ☐ P
3							☐ B ☐ P
4							☐ B ☐ P
5							☐ B ☐ P
If bone agents requested, select indication: ☐ osteo ☐ bone metastases ☐ hypercalcemia ☐ adjuvant breast cancer							
If ESAs requested, select indication: ☐ CKD ☐ CIA ☐ MDS							

IV. 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 #:
Has the member been receiving cancer treatments from the requesting treating provider? ☐ Yes ☐ No ☐ Unknown		
Is treating provider in-network? ☐ Yes ☐ No ☐ Unknown		
Requestor's Name:	Phone:	Fax:

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

SUPPORTIVE DRUGS REFERENCE PAGE

Note: This page is for reference and does not need to be faxed to Oncology Analytics.

Anti-emetics: nausea	
J1626	granisetron hydrochloride (Kytril) - IV
Q0166	granisetron hydrochloride (Kytril) - PO
J1627	granisetron ER (Sustol) - SubQ
J2405	ondansetron (Zofran) - IV
Q0162	ondansetron (Zofran) - PO
J2469	palonosetron (Aloxi) - IV
J8655	netupitant/palonosetron HCl (Akynzeo) - PO
J1454	netupitant/palonosetron HCl (Akynzeo) - IV
J8670	rolapitant HCl (Varubi) - PO
J1453	fosaprepitant dimeglumine (Emend) - IV
J8501	aprepitant (Emend) – PO
J0185	aprepitant (Cinvanti) - IV
Request Notes: Include latest MD progress notes	
Bone Agents	
J0897	denosumab (Xgeva) – SQ
J0897	denosumab (Prolia) – SQ
J3489	zoledronic acid (Zometa) - IV
J3489	zoledronic acid (Reclast) - IV
J2430	pamidronate (Aredia) – IV
Request Notes: Include bone scan and bone density test results and latest MD progress notes.	

Erythropoiesis-stimulating agents (ESA): anemia	
J0885	epoetin alfa (Procrit) – SQ
Q5106	epoetin alfa-epbx (Retacrit) – SQ
J0881	darbepoetin alfa (Aranesp) - SQ
Request Notes: Include recent CBC, Iron Sat % and Ferritin. EPO level for initiation with MDS. Check indication for use on the request form: chronic kidney disease (CKD), chemotherapy induced anemia (CIA) or myelodysplastic syndrome (MDS)	
Granulocyte Colony Stimulating Growth Factors (G-CSF): neutropenia	
Q5101	filgrastim-sndz (Zarxio) – SQ
J2505	pegfilgrastim (Neulasta) – SQ
J1442	filgrastim (Neupogen) – SQ
Q5110	filgrastim-aafi (Nivestym) – SQ
J1447	tbo-filgrastim (Granix) – SQ
Q5111	pegfilgrastim-cbqv (Udenyca) – SQ
Q5108	peg filg rastim-jmdb (Fulphila) – SQ
J9999	pegfilgras tim-bmez (Ziextenzo) – SQ
J2820	sargramostim (Leukine) – SQ
Request Notes: Include most recent CBC with diff, lowest ANC, any history of fever, febrile neutropenia, neutropenia on chemotherapy, current chemotherapy regimen, and a latest MD progress note.	