Updated: 03/2020
DMMA Approved: 03/2020

Request for Prior Authorization for Photofrin (porfimer sodium)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Photofrin (porfimer sodium) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Photofrin (porfimer sodium) Prior Authorization Criteria:

For all requests for Photofrin (porfimer sodium) all of the following criteria must be met:

- Must be prescribed by or in consultation with a gastroenterologist or oncologist
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Must not have any of the following:
  - Porphyria
  - Existing tracheoesophageal or bronchoesophageal fistula
  - Tumors eroding into a major blood vessel
  - Esophageal or gastric varices
  - Esophageal ulcers > 1 cm in diameter

Coverage may be provided with a diagnosis of esophageal cancer and the following criteria is met:

- Must have completely obstructing esophageal cancer or partially obstructing esophageal cancer that cannot be satisfactorily treated with laser therapy
- **Initial Duration of Approval:** 1 infusion (1 month)
- **Reauthorization criteria**
  - Must provide documentation of improvement as a result of initial treatment
  - Must be at least 30 days since last treatment
  - Maximum of 3 courses of treatment
- **Reauthorization Duration of Approval:** 1 infusion (1 month)

Coverage may be provided with a diagnosis of endobronchial cancer and the following criteria is met:

- Must be used for one of the following indications:
  - Treatment of microinvasive endobronchial non-small-cell lung cancer (NSCLC) when surgery and radiotherapy are not indicated
  - Reduction of obstruction and palliation of symptoms associated with completely or partially obstructing endobronchial NSCLC
- **Initial Duration of Approval:** 1 infusion (1 month)
- **Reauthorization criteria**
  - Must provide documentation of improvement as a result of initial treatment
  - Must be at least 30 days since last treatment
  - Maximum of 3 courses of treatment
- **Reauthorization Duration of Approval:** 1 infusion (1 month)

Coverage may be provided with a diagnosis of high-grade dysplasia in Barrett's esophagus and the following criteria is met:

- Must be used for ablation in members who do not undergo esophagectomy
- Must have documentation of biopsy to confirm the diagnosis
- **Initial Duration of Approval:** 1 infusion (1 month)
- **Reauthorization criteria**
  - Must provide documentation of improvement as a result of initial treatment
  - Must be at least 90 days since last treatment
  - Maximum of 3 courses of treatment
- **Reauthorization Duration of Approval:** 1 infusion (1 month)

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.

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PHOTOFRIN
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:

☐ Esophageal Cancer, ICD-10: _____
- Is the disease completely or partially-obstructing? ☐ Yes ☐ No
- Can it be treated with laser therapy? ☐ Yes ☐ No

☐ Microinvasive endobronchial non-small-cell lung cancer (NSCLC) when surgery and radiotherapy are not indicated, ICD-10: _____

☐ Endobronchial NSCLC that is completely or partially obstructing, ICD-10: _____

☐ High-grade dysplasia in Barrett's esophagus, ICD-10: _____
- Is the diagnosis confirmed by biopsy? *Documentation must be provided.* ☐ Yes, see attached fax ☐ No
- Is this being use for ablation instead of esophagectomy? ☐ Yes ☐ No

Does the member have any of the following contraindications to therapy: porphyria, existing tracheoesophageal or bronchoesophageal fistula, tumors eroding into a major blood vessel, esophageal or gastric varices, esophageal ulcers more than 1 cm in diameter? ☐ Yes ☐ No

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date