Highmark Wholecare
Pharmacy Division
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I. Requirements for Prior Authorization of Oncology Agents, Oral

A. Prescriptions That Require Prior Authorization

All prescriptions for Oncology Agents, Oral must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Oncology Agent, Oral, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Oncology Agent, Oral for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**

2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed the Oncology Agent, Oral by or in consultation with an oncologist or hematologist; **AND**

4. For a non-preferred Oncology Agent, Oral, **one** of the following:

    a. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Oncology Agents, Oral approved or medically accepted for the beneficiary's diagnosis
    b. Has a current history (within the past 90 days) of being prescribed the same non-preferred Oncology Agent, Oral (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred).

    See the Preferred Drug List (PDL) for the list of preferred Oncology Agents, Oral at: https://papdl.com/preferred-drug-list;

    NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR ONCOLOGY AGENTS, ORAL: The determination of medical necessity of a request for renewal of a prior authorization for an Oncology Agent, Oral that was previously approved will take into account whether the beneficiary:

1. Has documentation of a positive clinical response to the drug; **AND**

2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed the Oncology Agent, Oral by or in consultation with an oncologist or hematologist; **AND**

4. For a non-preferred Oncology Agent, Oral with a therapeutically equivalent brand or generic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand or generic that would not be expected to occur with the requested drug.

   See the PDL for the list of preferred Oncology Agents, Oral at: https://papdl.com/preferred-drug-list;

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Oncology Agent, Oral. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

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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)