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

A. Prescriptions That Require Prior Authorization

Prescriptions for Oncology Agents, Breast Cancer that meet any of the following conditions must be prior authorized:

1. A non-preferred Oncology Agent, Breast Cancer. See the Preferred Drug List (PDL) for the list of preferred Oncology Agents, Breast Cancer at: https://papdl.com/preferred-drug-list.

2. A prescription for letrozole.

B. Review of Documentation for Medical Necessity

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

1. For a non-preferred agent, has a history of therapeutic failure, contraindication, or intolerance to the preferred Oncology Agents, Breast Cancer; **AND**

2. For letrozole, is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication, excluding use to promote fertility. The requesting prescriber must provide documentation from the medical record of the diagnosis

   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, Breast Cancer. 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)