Updated: 08/2018
DMMA Approved: 09/2018

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

All requests for Portrazza (necitumumab) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Portrazza (necitumumab) Prior Authorization Criteria:

Disclaimer: All requests for Portrazza (necitumumab) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

For all requests for Portrazza (necitumumab) all of the following criteria must be met:

- The member is age 18 years or older
- The prescriber is a hematologist/oncologist
- The member will receive or has received a cardiac assessment prior to initiation of Portrazza
- The member will have routine monitoring of serum electrolytes prior to each dose of Portrazza during treatment and for at least eight weeks following completion of treatment
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided with a diagnosis of metastatic or advanced squamous cell Non-Small Cell Lung Cancer (NSCLC) and the following criteria is met:

- Portrazza will be used in combination with gemcitabine and cisplatin for first-line treatment
- The prescriber provides documentation explaining why the addition of Portrazza to cisplatin and gemcitabine as first-line therapy has benefits outweighing the increased risk of toxicity, adverse effects and documented limited efficacy (as compared to the combination of cisplatin/gemcitabine alone)
- The prescriber is aware that the National Comprehensive Cancer Network (NCCN) does not support the addition of a third agent to cisplatin and gemcitabine for the first-line treatment of metastatic squamous cell NSCLC
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Documentation member is tolerating and responding to treatment
    - Documentation member will continue to have routine monitoring of serum electrolytes prior to each dose of Portrazza during treatment and for at least eight weeks following completion of treatment
- **Reauthorization Duration of Approval:** 6 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.

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PORTRAZZA (NECITUMUMAB)
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) 325-6253 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)

Will a cardiac assessment be completed prior to initiation of Portrazza? ☐ Yes ☐ No
Will the member have routine monitoring of serum electrolytes prior to each dose of Portrazza during treatment and for at least eight weeks following completion of therapy? ☐ Yes ☐ No
Will Portrazza be used in combination with gemcitabine and cisplatin? ☐ Yes ☐ No
Is the prescriber aware that the National Comprehensive Cancer Network (NCCN) does not support the addition of a third agent to cisplatin and gemcitabine for the first-line treatment of metastatic squamous cell NSCLC? ☐ Yes ☐ No
Please provide your clinical rationale and supporting documentation for using Portrazza:
_____

REAUTHORIZATION

Will the member have routine monitoring of serum electrolytes prior to each dose of Portrazza during treatment and for at least eight weeks following completion of therapy? ☐ Yes ☐ No

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date

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