Updated: 03/2019
PARP Approved: 04/2019

Prior Authorization Criteria

Photofrin (porfimer sodium)

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

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

1) Must be prescribed by or in consultation with a gastroenterologist or oncologist
2) The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
3) 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.

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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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 Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 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:
Gateway 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:

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