Updated: 07/2019
PARP Approved: 08/2019

Prior Authorization Criteria

Prialt (ziconotide)

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

Coverage may be provided with a diagnosis of severe chronic pain and the following criteria is met:

- The member is age 18 years or older
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if applicable) or had an intolerance or contraindication to ALL of the following:
    - Nonpharmacologic treatment (e.g., cognitive behavioral therapy [CBT], exercise therapy, interventional treatments, and multimodal pain treatment)
    - A non-opioid medication at adequate dose, including but not limited to: NSAIDs, acetaminophen, gabapentin, amitriptyline, topical lidocaine, carbamazepine, duloxetine, fluoxetine
    - Two (2) short-acting and/or long-acting opioids
    - Intrathecal (IT) morphine at adequate doses
- Member does not have any of the following:
    - A pre-existing history of psychosis
    - Contraindication to intrathecal analgesia such as the infection at the microinfusion injection site, uncontrolled bleeding diathesis, or spinal canal obstruction that impairs circulation of cerebral spinal fluid
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria:**
    - Must provide documentation of clinical benefit
    - Must have no elevation in serum creatinine kinase
- **Reauthorization Duration of Approval:** 12 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.

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.

Gateway Health

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PRIALT (ziconotide intrathecal infusion)
PRIOR AUTHORIZATION FORM – PAGE 1 of 2

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)

Is Prialt being used to treat severe chronic pain? ☐ Yes ☐ No
Please provide applicable ICD10 Code:

Does the patient have a history of psychosis? ☐ Yes ☐ No
Does the patient have any contraindications to intrathecal analgesia? ☐ Yes ☐ No

Has the member tried at least one of the following nonpharmacological treatment? ☐ Yes ☐ No
Please select all that apply:
☐ cognitive behavioral therapy [CBT] ☐ exercise therapy
☐ interventional treatments ☐ multimodal pain treatment

Has the member tried and failed at least one of the following non-opioid medication at adequate dose, unless contraindicated or intolerant to therapy? ☐ Yes ☐ No
Please select all that apply:
☐ NSAIDs ☐ acetaminophen
☐ gabapentin ☐ amitriptyline
☐ topical lidocaine ☐ carbamazepine
☐ duloxetine ☐ fluoxetine

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

**** Continued on the next page ****

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PRIALT (ziconotide intrathecal infusion) PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2	
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	
MEMBER INFORMATION	
Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg
REAUTHORIZATION	
Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No Please describe:	
Does the member have any elevations in serum creatinine kinase? ☐ Yes ☐ No	
SUPPORTING INFORMATION or CLINICAL RATIONALE	
Prescribing Provider Signature	Date