Oncology Analytics/Gateway Health
Phone 888-916-2616 Fax 800-264-6128

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 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, contraindication, or intolerance of 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

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 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 tolerability and a positive clinical response to the medication; **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

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.

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.

Gateway Health℠ It's Wholecare.

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Chemotherapy and Supportive Care Prior Authorization Request Form

REQUEST DATE: _____ **TREATMENT START DATE:** _____ ☐ **Standard** ☐ **Expedited**

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 REQUEST ☐ New ☐ Retrospective ☐ Re-authorization

#	Billing Code	Drug Name	Route	Dose	Frequency & Schedule	Cycles or Refills	Billing Method (B = Buy & Bill or P = Pharmacy)
1							☐ B ☐ P
2							☐ B ☐ P
3							☐ B ☐ P
4							☐ B ☐ P

III. SUPPORTING CARE DRUGS REQUESTED (see attached drug list for reference)

#	Billing Code	Drug Name	Route	Dose	Frequency & Schedule	Condition (e.g. nausea)	Billing Method (B = Buy & Bill or P = Pharmacy)
1							☐ B ☐ P
2							☐ B ☐ P
3							☐ B ☐ P
4							☐ B ☐ P
5							☐ B ☐ P
If bone agents requested, select indication: ☐ osteo ☐ bone metastases ☐ hypercalcemia ☐ adjuvant breast cancer							
If ESAs requested, select indication: ☐ CKD ☐ CIA ☐ MDS							

IV. 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 #:
Has the member been receiving cancer treatments from the requesting treating provider? ☐ Yes ☐ No ☐ Unknown		
Is treating provider in-network? ☐ Yes ☐ No ☐ Unknown		
Requestor's Name:	Phone:	Fax:

SUBMIT PROGRESS NOTES, CHEMO ORDERS, LABS, PATHOLOGY AND IMAGING RESULTS WITH REQUEST.

SUPPORTIVE DRUGS REFERENCE PAGE

Note: This page is for reference and does not need to be faxed to Oncology Analytics.

Anti-emetics: nausea	
J1626	granisetron hydrochloride (Kytril) - IV
Q0166	granisetron hydrochloride (Kytril) - PO
J1627	granisetron ER (Sustol) - SubQ
J2405	ondansetron (Zofran) - IV
Q0162	ondansetron (Zofran) - PO
J2469	palonosetron (Aloxi) - IV
J8655	netupitant/palonosetron HCl (Akynzeo) - PO
J1454	netupitant/palonosetron HCl (Akynzeo) - IV
J8670	rolapitant HCl (Varubi) - PO
J1453	fosaprepitant dimeglumine (Emend) - IV
J8501	aprepitant (Emend) – PO
J0185	aprepitant (Cinvanti) - IV
Request Notes: Include latest MD progress notes	
Bone Agents	
J0897	denosumab (Xgeva) – SQ
J0897	denosumab (Prolia) – SQ
J3489	zoledronic acid (Zometa) - IV
J3489	zoledronic acid (Reclast) - IV
J2430	pamidronate (Aredia) – IV
Request Notes: Include bone scan and bone density test results and latest MD progress notes.	

Erythropoiesis-stimulating agents (ESA): anemia	
J0885	epoetin alfa (Procrit) – SQ
Q5106	epoetin alfa-epbx (Retacrit) – SQ
J0881	darbepoetin alfa (Aranesp) - SQ
Request Notes: Include recent CBC, Iron Sat % and Ferritin. EPO level for initiation with MDS. Check indication for use on the request form: chronic kidney disease (CKD), chemotherapy induced anemia (CIA) or myelodysplastic syndrome (MDS)	
Granulocyte Colony Stimulating Growth Factors (G-CSF): neutropenia	
Q5101	filgrastim-sndz (Zarxio) – SQ
J2505	pegfilgrastim (Neulasta) – SQ
J1442	filgrastim (Neupogen) – SQ
Q5110	filgrastim-aafi (Nivestym) – SQ
J1447	tbo-filgrastim (Granix) – SQ
Q5111	pegfilgrastim-cbqv (Udenyca) – SQ
Q5108	peg filg rastim-jmdb (Fulphila) – SQ
J9999	pegfilgras tim-bmez (Ziextenzo) – SQ
J2820	sargramostim (Leukine) – SQ
Request Notes: Include most recent CBC with diff, lowest ANC, any history of fever, febrile neutropenia, neutropenia on chemotherapy, current chemotherapy regimen, and a latest MD progress note.	