Updated: 07/2019
DMMA Approved: 07/2019

**Request for Prior Authorization for Prialt (ziconotide intrathecal infusion)**
**Website Form – www.highmarkhealthoptions.com**
**Submit request via: Fax - 1-855-476-4158**

All requests for Prialt (ziconotide intrathecal infusion) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

**Prialt (ziconotide intrathecal infusion) Prior Authorization Criteria:**

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 infection at the microinfusion injection site, uncontrolled bleeding diathesis, and spinal canal obstruction that impairs circulation of CSF
- 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.

Highmark Delaware HEALTH OPTIONS

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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 Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
**PHONE**: (844) 325-6251 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)**

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) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

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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 Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
**PHONE**: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

**MEMBER INFORMATION**

| | |
|---|---|
| Member Name: | DOB: |
| Health Options 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 |
|---|---|
| | |