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) 325-6253 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)

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

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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