Updated: 08/2018
PARP Approved: 8/2018

Gateway Health
Prior Authorization Criteria
Portrazza (necitumumab)

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

Portrazza (necitumumab) Prior Authorization Criteria:
Disclaimer: All requests for Portrazza (necitumumab) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

For all requests for Portrazza (necitumumab) all of the following criteria must be met:

- The member is age 18 years or older
- The prescriber is a hematologist/oncologist
- The member will receive or has received a cardiac assessment prior to initiation of Portrazza
- The member will have routine monitoring of serum electrolytes prior to each dose of Portrazza during treatment and for at least eight weeks following completion of treatment
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided with a diagnosis of metastatic or advanced squamous cell Non-Small Cell Lung Cancer (NSCLC) and the following criteria is met:

- Portrazza will be used in combination with gemcitabine and cisplatin for first-line treatment
- The prescriber provides documentation explaining why the addition of Portrazza to cisplatin and gemcitabine as first-line therapy has benefits outweighing the increased risk of toxicity, adverse effects and documented limited efficacy (as compared to the combination of cisplatin/gemcitabine alone)
- The prescriber is aware that the National Comprehensive Cancer Network (NCCN) does not support the addition of a third agent to cisplatin and gemcitabine for the first-line treatment of metastatic squamous cell NSCLC
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Documentation member is tolerating and responding to treatment
    - Documentation member will continue to have routine monitoring of serum electrolytes prior to each dose of Portrazza during treatment and for at least eight weeks following completion of treatment
- **Reauthorization Duration of Approval:** 6 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.

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PORTRAZZA (Necitumumab)
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: ☐Hematologist ☐Oncologist ☐Other:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
WVFH 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: ☐ metastatic or advanced squamous cell Non-Small Cell Lung Cancer (NSCLC)
☐ Other: _____ ICD-10 Code: _____

Has/will the member receive a cardiac assessment prior to the initiation of Portrazza? ☐ Yes ☐ No

Will the member have routine monitoring of serum electrolyters prior to each dose of Portrazza during treatment and for at least 8 weeks following completion of treatment? ☐ Yes ☐ No

For first-line treatment, will the medication be used in combination with gemcitabine and cisplatin? ☐ Yes ☐ No
Is the prescriber aware that the National Comprehensive Cancer Network (NCCN) does not support the addition of a third agent to gemcitabine and cisplatin for the first-line treatment of metastatic quamous cell NSCLC? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

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

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PORTRAZZA (Necitumumab)
PRIOR AUTHORIZATION FORM (CONTINUED)– PAGE 2 of 2

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MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REAUTHORIZATION

Is the member tolerating and responding to treatment? ☐ Yes ☐ No

Will the member continue to have routine monitoring of serum electrolytes during treatment and for 8 weeks following completion of treatment? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date