Updated: 02/2020
DMMA Approved: 02/2020

Request for Prior Authorization for Oncology Medications
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Oncology Medications require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Oncology Medications Prior Authorization Criteria:

Grandfathering provision: prior authorization criteria will apply to new starts only.

This policy applies to every oncology product that does not have its own specific policy

For all requests for oncology medications all of the following criteria must be met:

- The member has a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package insert, listed in nationally recognized compendia, or peer reviewed medical literature for the determination of medically-accepted indications
- If not indicated as a first line agent, either in the FDA approved package insert, nationally recognized compendia, or peer reviewed medical literature, must provide documentation of previous therapies tried and failed (previous therapies must include those recommended by the FDA approved package insert, nationally recognized compendia, or peer reviewed medical literature)
- Prescribed by, or in consultation with, an oncologist or hematologist
- Unless indicated as monotherapy, must be used in combination with other chemotherapeutic or adjuvant agents according to the FDA approved prescribing information, nationally recognized compendia, or peer reviewed medical literature
- If a test with adequate ability to confirm a disease mutation exists, documentation that the test was performed to confirm the mutation
- The member does not have any contraindications to the requested medication
- For non-preferred agents, the member has had a trial and failure of a preferred agent or a clinically submitted reason for not having a trial of a preferred agent
- The prescribed quantity and dosing regimen is in accordance with the manufacturer's published dosing guidelines, nationally recognized compendia, or peer reviewed medical literature
- **Initial Duration of Approval:** as requested with a maximum of 12 months.
- **Reauthorization Criteria:**
    - Documentation that the member had a positive clinical response and is able to tolerate therapy.
- **Reauthorization Duration of Approval:** as requested with a maximum of 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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK. Delaware HEALTH OPTIONS

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ONCOLOGY MEDICATIONS PRIOR AUTHORIZATION FORM

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)

Diagnosis: ICD-10 Code:

If a test with adequate ability to confirm a disease mutation exists, was the test performed to confirm the mutation?
☐ Yes ☐ No ☐ Not applicable

Is the requested drug being used in combination with other chemotherapeutic or adjuvant agents?
☐ Yes, other medications being used: ☐ No

Does the member have any contraindications to the requested oncology medication? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Has the member experienced a positive clinical response and is able to tolerate treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date