Updated: 09/2019
PARP Approved: 10/2019

Prior Authorization Criteria

Oncology Medications, IV/Injectable

All requests for IV/Injectable Oncology Medications require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

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

For all requests for IV/Injectable 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 requests to start a new non-formulary agent, the member has had a trial and failure of a formulary agent or a clinically submitted reason for not having a trial of a formulary 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.

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.

Gateway Health

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ONCOLOGY MEDICATIONS, IV/INJECTABLE
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:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway 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: 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