ATRIO HEALTH PLANS

Chemotherapy: CD30 Antibody
Adcetris (brentuximab vedotin) J9042
Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**NEW START - Start Date:_____**	☐	**Continuation** (within 365 days)**:** Date of last treatment _____
☐	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug ☐ Self-administered	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____ **Date:**_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

For questions or assistance, please contact Customer Service at 1-877-672-8620, daily, 8am – 8pm (PST) (TTY users should call 1-800-735-2900).

Prior Authorization Group – Oncology: CD30-Directed Antibody PA

Drug Name(s):
ADCETRIS
BRENTUXIMAB VEDOTIN

Criteria for approval of Prior Authorization Drug:
1. Prescribed for an approved FDA diagnosis (as listed below):
2. Prescribed by, or in consultation with an oncologist or other cancer specialist related to the diagnosis.
3. Drug is being used appropriately per CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
4. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:
Cannot be prescribed for experimental or investigational use.

Prescriber Restrictions:
Oncologist or other cancer specialist

Coverage Duration:
New Start: Approval will be for 6 months
Continuation: Approval will be for 12 months

FDA Indications:
Adcetris
1. Anaplastic large T-cell systemic malignant lymphoma, After failure of a multi-agent chemotherapy regimen
2. Anaplastic large T-cell systemic malignant lymphoma, Or other CD30-expressing peripheral T cell lymphomas, previously untreated, in combination with cyclophosphamide, DOXOrubicin, and predniSONE
3. Hodgkin's disease, classical, after failure of autologous hematopoietic stem cell transplant (auto-HSCT) or after failure of at least 2 multiagent chemotherapy regimens in patients not eligible for auto-HSCT
4. Hodgkin's disease, classical, consolidation therapy after autologous hematopoietic stem-cell transplantation (auto-HSCT), in patients at high risk of relapse or progression
5. Hodgkin's disease, classical, first-line treatment, stage III or IV disease, in combination with DOXOrubicin, vinBLAStine, and dacarbazine
6. Mycosis fungoides, CD30-expressing, in patients who have received prior systemic therapy
7. Primary cutaneous lymphoma, Anaplastic large cell, in patients who have received prior systemic therapy

Off-Label Uses:
1. Hodgkin's disease, Relapsed or refractory

Age Restrictions:
N/A

Other Clinical Considerations:
Criteria as per NCCN or other FDA-approved cancer related guidelines.

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/073956/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/E917A1/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=930001&contentSetId=100&title=Brentuximab+Vedotin&servicesTitle=Brentuximab+Vedotin&brandName=Adcetris&UserMdxSearchTerm=Adcetris&=null#