



**Chemotherapy: Bladder Cancer  
Valstar (valrubicin) J9357  
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.

<input type="checkbox"/>	<b>NEW START - Start Date:</b> _____	<input type="checkbox"/>	<b>Continuation</b> (within 365 days): Date of last treatment _____
<input type="checkbox"/>	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 <input type="checkbox"/> 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.**

## Prior Authorization Group – Oncology: Multiple Myeloma PA

### Drug Name(s):

VALSTAR

VALRUBICIN

### 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:

Valstar

1. Cancer in situ of urinary bladder, BCG-refractory disease, in patients not candidates for immediate cystectomy

### Off-Label Uses:

N/A

### Age Restrictions:

The safety and effectiveness of valrubicin for intravesical installation have not been established in pediatric patients.

### Other Clinical Considerations:

Criteria as per NCCN or other FDA-approved cancer related guidelines.

### Resources:

[https://www.micromedexsolutions.com/micromedex2/librarian/CS/2DEA8E/ND\\_PR/evidencexpert/ND\\_P/evidencexpert/DUPLICATIONSHIELDSYNC/FDBD23/ND\\_PG/evidencexpert/ND\\_B/evidencexpert/ND\\_AppProduct/evidencexpert/ND\\_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=924828&contentSetId=100&title=Valrubicin&servicesTitle=Valrubicin&brandName=Valstar&UserMdxSearchTerm=valstar&=null#](https://www.micromedexsolutions.com/micromedex2/librarian/CS/2DEA8E/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/FDBD23/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=924828&contentSetId=100&title=Valrubicin&servicesTitle=Valrubicin&brandName=Valstar&UserMdxSearchTerm=valstar&=null#)