

**Contains Confidential Patient Information**

**Abraxane® (paclitaxel protein-bound particles) PreDetermination of Medical Benefits  
Complete form in its entirety and fax to UM Call Center at (404) 848-2448**

Click on grey boxes to type

Request Date:            /            /

Initial Authorization Request

Re-Authorization Request; List Prior Auth Ref # \_\_\_\_\_

Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions (800-824-2642) FAX

Ship Medication to:  MD Office  Patient's Home  Other: (please specify)

**1. PATIENT INFORMATION – ALL INFORMATION REQUIRED**

Patient Last Name	Patient First Name	Patient ID Number	Patient DOB / /
Contact Phone Number ( ) -	Primary Diagnosis	ICD-9 Code(s)	Patient's Weight _____ (lbs)

**2. PHYSICIAN INFORMATION – ALL INFORMATION REQUIRED**

Physician Last Name	Physician First Name	Physician DEA or NPI Number	Physician Tax ID
Address		City	State      Zip Code
Office Phone Number ( ) -	Office Fax Number ( ) -	Office Contact Name and ext.	Physician Specialty

**3. MEDICATION INFORMATION - ALL INFORMATION REQUIRED**

HCPCS Code/Drug Name J9264-Abraxane	Dose to be administered (mg/m2)	When did the member first start this drug?
Frequency (weeks)	Duration (weeks)	Start Date For This Request

**Place of Service**  
 MD office     Pt's Home     Other: (please specify)

**4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

NOTE: To avoid delays, please complete this form in its entirety.

**(1) Breast Cancer**

Yes     No    Does the patient have metastatic or recurrent disease with hormone receptive negative?  
 Yes     No    Does the patient have metastatic or recurrent disease with hormone receptive positive?  
 Yes     No    If Hormone receptive positive, is it with visceral crisis?  
 Yes     No    If Hormone receptive positive, is tumor refractive to endocrine therapy?

**(2) Non-Small Cell Lung Cancer**

Yes     No    Has the patient experienced hypersensitivity reactions after receiving paclitaxel or docetaxel despite premedication?  
 Yes     No    Are standard hypersensitivity medications contraindicated?

**(3) Other Use(s)** (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

**5. PHYSICIAN SIGNATURE**

Prescriber's or Authorized Representative's Signature:  _____	Date:    /    /
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Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

**IMPORTANT WARNING:** This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is **STRICTLY PROHIBITED**. If you have received this message by error, please notify us immediately at 800-722-6614 and destroy the related message or return the document to us at 3350 Peachtree Rd. NE, Atlanta, GA 30326. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.

Medical Policy Reference can be found at: [www.cbbsga.com](http://www.cbbsga.com).

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.