

Contains Confidential Patient Information

**Faslodex® (fulvestrant)
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 J9395-Faslodex		Dose to be administered (mg)		When did the member first start this drug?	
Frequency (weeks)		Duration (weeks)		Start Date For This Request	

Place of Service: Home Office Dialysis Center Outpatient Hospital Ambulatory Infusion Ambulatory Infusion Center
 Other: _____

4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

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

(1) Breast Cancer

Yes No Is this metastatic or recurrent disease?
What were the results of the hormone receptor testing?
 Positive
 Negative
 Yes No Does the patient have asymptomatic visceral disease?
 Yes No Does the patient have involvement of bone or soft tissue?
 Unknown

What is the patient's menopausal status?
 Premenopausal
 Yes No Has the patient been treated with ovarian ablation or suppression therapy?
 Postmenopausal

(2) Breast Cancer in Males

Yes No Is this metastatic or recurrent disease?
What were the results of the hormone receptor testing?
 Positive
 Negative
 Yes No Does the patient have asymptomatic visceral disease?
 Yes No Does the patient have involvement of bone or soft tissue?

Yes No Is the patient undergoing suppression of testicular steroidogenesis?

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(2) 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: ____/____/____

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.bcbsga.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.