

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 J9293-Novantrone	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: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Ambulatory Infusion <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Other: _____		

4. APPROVAL CRITERIA: To avoid delays; please complete this form in its entirety. Answer questions in Part A and appropriate questions in part B based on the patient's diagnosis.

Part A

Yes No Has the patient has undergone cardiac assessment prior to initiation of therapy?

Yes No Was the left ventricular ejection fraction normal (greater than 45%)?

Yes No Will a cardiac assessment be conducted at appropriate intervals during and after completion of therapy?

Part B

1. Leukemia

Yes No Does the patient have acute non-lymphocytic (ANLL)?

Yes No Is this to be used as initial therapy?

Yes No Does the patient have myelogenous, promyelocytic, monocytic, or erythroid acute leukemia?

2. Multiple sclerosis (MS)

Yes No Is this to be used for reducing neurologic disability and/or frequency of clinical relapses?

Yes No Does the patient have secondary progressive, progressive relapsing, or worsening relapsing-remitting MS?

3. Prostate Cancer

Yes No Does the patient have advanced prostate cancer?

Yes No Is the prostate cancer hormone refractory?

Yes No Will this be used in combination with corticosteroids?

4. Breast Cancer

Yes No Does this patient have breast cancer?

5. Liver Carcinoma

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Yes No

Does this patient have liver cancer?

Ovarian Cancer

Yes No

Does the patient have ovarian cancer?

**6. Hodgkin's
Lymphoma**

Yes No

Is the patient disease progressive or relapsed?

Yes No

Is this to be used as second line treatment?

Yes No

Is this to be used prior to autologous stem cell rescue?

Yes No

Was the patient previously treated with chemotherapy alone or in combination with radiation?

**7. Non-Hodgkin's
Lymphoma (NHL)**

Please indicate the type of Non-Hodgkin's Lymphoma the patient has

- Diffuse B-cell lymphoma
- Follicular lymphoma
- Gastric MALT lymphoma
- Mantle cell lymphoma
- Nodal marginal zone lymphoma
- Non-gastric MALT lymphoma
- Peripheral T-cell lymphoma
- Splenic marginal zone lymphoma
- Other _____

8. 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.

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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.