Anthem UM Services, Inc.

Contains Confidential Patient Information

Vidaza ® (azacitidine) 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	Dose to be administered (mg/m2)	When did the member first start this drug?
J9025 - Vidaza		
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. Answer questions based on the patient's diagnosis.

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

Myelodysplastic Syndrome

☐ Yes ☐ No Does the patient have Refractory anemia (RA)?

☐ Yes ☐ No Does the patient have Refractory anemia with ringed sideroblasts (RARS)? **Please check all that apply:**
- ☐ Accompanied by neutropenia or
- ☐ Accompanied by thrombocytopenia or
- ☐ Requiring transfusions

☐ Yes ☐ No Does the patient have Refractory anemia with excess blasts (RAEB)?

☐ Yes ☐ No Does the patient have Refractory anemia with excess blasts in transformation (RAEB-T)?

☐ Yes ☐ No Does the patient have Chronic myelomonocytic leukemia (CMMoL)?

☐ Yes ☐ No Does the patient have Acute myeloid leukemia?

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.