

Pharmacy

PRIOR AUTHORIZATION FORM

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Adcetris[®] (brentuximab)

URGENT (life threatening)

Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature

Date

PRODUCT INFORMATION

Adcetris 50 mg vial for IV infusion

Dose: _____

Start Date: _____

BILLING INFORMATION

Place of administration:

- Provider's Office
 Outpatient Infusion Center

Center Name: _____

Billing Options:

- Physician buy and bill
 Specialty Vendor: _____
 Other: _____

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for Adcetris[®] (brentuximab) requires the following information to certify:

Patient must have met the following requirements:

- Adult patients with Hodgkin lymphoma after failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regimens.
OR
- Adult patients with Systemic anaplastic large cell lymphoma (ALCL) after failure of at least one prior multi-agent chemotherapy regimen.

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for Adcetris[®] (brentuximab) requires the following information to certify:

A. What is the patient's diagnosis?

- a. classical Hodgkin Lymphoma (CHL) with CD30-expressing cells
 - i. Did the patient fail an autologous stem cell transplant?
 - 1. Yes
 - 2. No – failure of two multi-agent chemotherapy regimens is required
 - ii. What previous chemotherapy regimens have been used in this patient?
 - 1. Regimen 1: _____
 - 2. Regimen 2: _____
- b. systemic anaplastic large cell lymphoma (ALCL)
 - i. What previous chemotherapy regimen has been used in this patient?
 - 1. Regimen1: _____
- c. Other – *Rationale for use:* _____

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX