AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Orencia® (abatacept) **(J0129) (IV INFUSION ONLY) (Medical)**
Graft Versus Host Disease (GVHD)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Recommended Dosage: IV: 10mg/kg (maximum: 1,000 mg/dose) on the day prior to transplant (day -1), followed by 10mg/kg (maximum: 1,000mg/dose) on days 5, 14, and 28 post-transplant

Quantity Limit: 4 vials for a total of 4 doses

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member is 2 years of age or older
- ❑ Member is undergoing a hematopoietic stem cell transplant (HSCT) from a matched or 1 allele-mismatched unrelated-donor
- ❑ Medication will be used for prophylaxis of acute graft versus host disease (aGVHD) **(IV formulation only)**
- ❑ Medication will be used in combination with a calcineurin inhibitor (e.g., cyclosporine, tacrolimus) and methotrexate **(verified by chart notes or pharmacy paid claims)**
- ❑ Member will receive antiviral prophylactic treatment for Epstein-Barr Virus (EBV) reactivation and prophylaxis will continue for 6 months post-transplantation **(verified by chart notes or pharmacy paid claims)**
- ❑ Member will be monitored for both EBV reactivation and cytomegalovirus (CMV) infection/reactivation

Prophylaxis for aGVHD may <u>NOT</u> be renewed

Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  <u>OR</u>

- ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call AvMed's Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****<u>Previous therapies will be verified through pharmacy paid claims or submitted chart notes.</u>****

***Approved by Pharmacy and Therapeutics Committee**: 3/17/2022
REVISED/UPDATED: ~~5/4/2022;~~ **6/16/2022**