SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY 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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Vijoice® (alpelisib)

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

Member Name: _____

Member Sentara #: _____ **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:** _____

Quantity Limits:

- **50 mg therapy pack = 1 tablet per day**
- **125 mg therapy pack = 1 tablet per day**
- **250 mg therapy pack = 56 tablets (1 box) per 28 days**

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.

Initial Authorization: 6 months

- ❑ Member is 2 years of age or older
- ❑ Requesting provider is an oncologist, having a specialty in treating patients with PIK3CA-Related Overgrowth Spectrum

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- ❑ Member has a diagnosis of PIK3CA-Related Overgrowth Spectrum, confirmed by **BOTH** of the following:
  - ❑ Documented evidence for a PIK3CA gene mutation
  - ❑ Member has at least one target lesion identified on imaging
- ❑ Member's condition is severe or life-threatening requiring systemic therapy **(documentation of severe clinical manifestations include Congenital Lipomatous Overgrowth, Vascular malformations, Epidermal nevi, Scoliosis/skeletal and spinal [CLOVES], Facial Infiltrating Lipomatosis [FIL], Klippel-Trenaunay Syndrome [KTS], Megalencephaly-Capillary Malformation Polymicrogyria [MCAP])**
- ❑ Member's age and weight meet **ONE** of the following:
  - ❑ Age 2-5 years: 50 mg (1 tablet) per day
  - ❑ Age 6-17 years: 125 mg (1 tablet) per day
  - ❑ Age > 18 years: 250 mg therapy pack (2 tablets) per day

Reauthorization: 12 months. 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 responding positively to therapy as evidenced by subsequent imaging scan with a reduction in sum of measurable lesion volume assessed across 1 to 3 target lesions **(radiological response defined as a ≥ 20% reduction from baseline in the sum of target lesion volume)**
- ❑ Member is **NOT** experiencing any toxicity from therapy (e.g., severe cutaneous adverse reactions, severe hyperglycemia, severe lung toxicity)
- ❑ Member's age and weight continues to meet **ONE** of the following **(Provider please note: If request is for a dose increase, new dose must NOT exceed any of the following)**:
  - ❑ Age 2-5 years: 50 mg (1 tablet) per day
  - ❑ Age 6-17 years: 125 mg (1 tablet) per day
  - ❑ Age > 18 years: 250 mg therapy pack (2 tablets) per day

Medication being provided by Specialty Pharmacy - PropriumRx

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

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****