

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: Kepivance® (palifermin) J2425 (Medical)

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: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

- 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.

Limitations of use: Safety and efficacy have not been established for nonhematologic malignancies. Palifermin is not recommended with conditioning regimens containing melphalan 200 mg/m². Palifermin was not effective in decreasing the incidence of severe mucositis in patients with hematologic malignancies receiving myelotoxic therapy in the setting of allogeneic hematopoietic stem cell support.

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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.

Length of Authorization: Date of Service (one-time authorization); 6 Total Doses [3 consecutive days before and 3 consecutive days after myelotoxic therapy]

- Prescribed by or in consultation with an oncologist, and/or transplant specialist
- Member has a hematologic malignancy (e.g., non-Hodgkin's lymphoma, Hodgkin's lymphoma, acute myelogenous leukemia (AML), acute lymphoblastic leukemia (ALL), chronic lymphocytic leukemia (CLL), chronic myelogenous leukemia, (CML), acute monocytic leukemia (AMoL) or multiple myeloma)
- Member is scheduled for autologous hematopoietic stem cell transplantation (autoHSCT)
- Member will undergo preparative regimen for auto-HSCT which is expected to result in mucositis \geq grade 3 in the majority of patients

Medication being provided by (check applicable box(es) below):

- Location/site of drug administration:** _____
NPI or DEA # of administering location: _____

OR

- Specialty Pharmacy**

For urgent reviews: Practitioner should call AvMed Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed Health'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.*****

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