JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Alimta

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:
*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

Criteria Questions:

1. What is the diagnosis?
   - ❑ Non-small cell lung cancer (NSCLC)
   - ❑ Malignant pleural mesothelioma
   - ❑ Malignant peritoneal mesothelioma
   - ❑ Thymoma or thymic carcinoma
   - ❑ Bladder cancer (transitional cell urothelium cancer)
   - ❑ Epithelial ovarian cancer
   - ❑ Fallopian tube cancer
   - ❑ Primary peritoneal cancer
   - ❑ Primary central nervous system (CNS) lymphoma
   - ❑ Pericardial mesothelioma
   - ❑ Tunica vaginalis testis mesothelioma
   - ❑ Cervical cancer
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #5*
4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions*
5. Will the requested medication be given in any of the following regimens?
   - ❑ As a single agent
   - ❑ As a single agent for second-line therapy
   - ❑ As second-line treatment
   - ❑ In combination with cisplatin or carboplatin
   - ❑ In combination with bevacizumab and either cisplatin or carboplatin
   - ❑ None of the above

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Non-Small Cell Lung Cancer (NSCLC)

6. What is the histology for the disease?
   - ❑ Non-squamous histology
   - ❑ Squamous histology

Section B: Bladder cancer (transitional cell urothelium cancer)

7. What is the clinical setting in which the requested medication will be used?
   - ❑ Locally advanced disease
   - ❑ Relapsed disease
   - ❑ Metastatic disease
   - ❑ Other

Section C: Epithelial Ovarian Cancer, Fallopian Tube Cancer, Primary Peritoneal Cancer, or Cervical Cancer

8. What is the clinical setting in which the requested medication will be used?
   - ❑ Persistent disease
   - ❑ Recurrent disease
   - ❑ None of the above

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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