Arkansas Medicaid Prescription Drug Program
Oncology Medication Prior Authorization Fax Form
Fax completed form and required documentation to Arkansas Medicaid Pharmacy Program

Fax: 800-424-5851 For questions, call: 501-683-4120.

This prior authorization request form pertains to pharmacy processed oncology medications. Oncology medications obtained through medical billing should not be requested with this form.

Prime Therapeutics partners with CoverMyMeds to allow for the submission of electronic PA requests. **For faster coverage determinations**, go to www.CoverMyMeds.com

If the following information is not complete, correct, or legible, the prior authorization (PA) process can be delayed. Please use one form per beneficiary.

Requestor Name: _____ **Title**: _____

BENEFICIARY INFORMATION

Medicaid ID: _____ Date of Birth: _____

Beneficiary Last Name: _____

Beneficiary First Name: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber NPI: _____ DEA Number: _____

Prescriber Phone: _____ Prescriber Fax: _____

DIAGNOSIS AND TREATMENT HISTORY

Diagnosis: _____

ICD-10 Code: _____

☐ New Therapy ☐ Renewal

If renewal, duration of therapy (specific dates): _____ to _____

DRUG INFORMATION

Drug Name: _____

Drug Strength: _____ Dosage Form: _____

Directions: _____

Beneficiary Name (Last, First): _____

DRUG INFORMATION (CONTINUED)

Medications Covered as a Pharmacy Claim (select requested medication(s))				
☐ Abiraterone	☐ Afinitor tablets	☐ Afinitor Disp (PPB)	☐ Akeega	☐ Alecensa
☐ Alunbrig	☐ Anastrazole*	☐ Arimidex*	☐ Augtyro	☐ Avmapki/ Fakzynja
☐ Ayvakit	☐ Balversa	☐ BESREMi	☐ Bosulif	☐ Braftovi
☐ Brukinsa	☐ Cabometyx	☐ Calquence	☐ Caprelsa	☐ Cometriq
☐ Copiktra	☐ Cotellic	☐ Danziten	☐ Dasatinib	☐ Daurismo
☐ Erivedge	☐ Erleada	☐ Erlotinib	☐ Everolimus	☐ Exkivity
☐ Femara*	☐ Fotivda	☐ Fruzaqla	☐ Gavreto	☐ Gefitinib
☐ Gilotrif	☐ Gomekli*	☐ Hernexeos	☐ Ibrance	☐ Ibtrozi
☐ Iclusig	☐ Idhifa	☐ Imbruvica	☐ Imkeldi	☐ Inlyta
☐ Inqovi	☐ Inrebic	☐ Iressa	☐ Itovebi	☐ Iwilfin
☐ Jakafi	☐ Jaypirca	☐ Kisqali	☐ Kisqali/Femara	☐ Koselugo*
☐ Krazati	☐ Lapatinib	☐ Lazcluze	☐ Lenalidomide	☐ Lenvima
☐ Letrozole*	☐ Lonsurf	☐ Lorbrena	☐ Lumakras	☐ Lynparza
☐ Lytgobi	☐ Mekinist	☐ Mektovi	☐ Mercaptopurine Susp	☐ Modeyso
☐ Nerlynx	☐ Nexavar (PPB)	☐ Ninlaro	☐ Nubeqa	☐ Odomzo
☐ Ogsiveo	☐ Ojemda	☐ Ojjaara	☐ Onureg	☐ Orgovyx
☐ Orserdu	☐ Pazopanib	☐ Pemazyre	☐ Phyrago	☐ Piqray
☐ Pomalyst	☐ Purixan	☐ Qinlock	☐ Retevmo	☐ Revlimid (PPB)
☐ Revuforj	☐ Rezlidhia	☐ Rezurock*	☐ Romvimza	☐ Rozlytrek
☐ Rubraca	☐ Rydapt	☐ Scemblix	☐ Soltamox	☐ Sprycel (PPB)
☐ Stivarga	☐ Sunitinib	☐ Sutent (PPB)	☐ Tabrecta	☐ Tafinlar
☐ Tagrisso	☐ Talzenna	☐ Tarceva	☐ Targretin gel	☐ Tasigna (PPB)
☐ Tazverik	☐ Temodar	☐ Temozolomide	☐ Tepmetko	☐ Tibsovo
☐ Truqap	☐ Tukysa	☐ Turalio*	☐ Tykerb	☐ Valchlor
☐ Vanflyta	☐ Venclexta	☐ Verzenio	☐ Vitrakvi	☐ Vizimpro
☐ Vonjo	☐ Voranigo	☐ Votrient (PPB)	☐ Welireg	☐ Xalkori
☐ Xospata	☐ Xpovio	☐ Xtandi	☐ Yonsa	☐ Zejula
☐ Zelboraf	☐ Zolinza	☐ Zydelig	☐ Zykadia	☐ Zytiga

PPB=Plan prefers brand name

Beneficiary Name (Last, First): _____

Medications excluded from the above table may fall into one of the following categories:

- Available without prior authorization requirements
- New to market medication
- Covered as a medical claim

Verification of PA status can be found on the pharmacy vendor website: https://ar.primetherapeutics.com/drug-lookup

CRITERIA

Policy guidelines:

- Prior authorization criteria for oncology medications covered under this policy will be based on the FDA-approved label and support found in the NCCN treatment guidelines with NCCN level of evidence 1 or 2a unless otherwise noted with an asterisk*.
- Medications noted with an asterisk follow DUR Board approved criteria found on the pharmacy vendor website: https://ar.primetherapeutics.com. Arimidex® (anastrazole) and Femara® (letrozole) will process at point-of-sale without a prior authorization if the beneficiary's medical history includes a female with breast cancer billed in the last 3 years.
- Requests for an indication, dosage, age, or duration of treatment outside of the FDA-approved label and NCCN treatment recommendations are considered off-label.
- Off-label requests will be reviewed for medical necessity on a case-by-case basis while referencing official compendia, peer-reviewed literature, and tumor board (case conference) review along with documentation submitted with the request.
- All prior authorization requests must be submitted by or in consultation with an oncologist or hematologist.
- Documentation supporting the prior authorization request must be submitted at the time of the request.
- Quantity limits apply to all medications based on FDA-approved dosing.

When submitting an initial prior authorization request for an oncology product, providing all pertinent information with the initial request will expedite reviews. At a minimum, the prescriber **must** submit:

☐ Current chart notes

☐ Type of cancer with documentation of any mutations

☐ All previous therapies tried with timelines and response (i.e., medications and surgeries)

☐ Current labs specific to the type of cancer and treatment requesting (e.g., complete blood count, renal function labs, liver function panel)

☐ Specific imaging requirements per the package insert (e.g., MRI or CT imaging)

☐ Letter of medical necessity outlining the rationale for the treatment requested especially if the request is off-label.

☐ Current weight or body surface area

Beneficiary Name (Last, First): _____

CRITERIA (CONTINUED)

☐ Dose requested.

☐ Pregnancy test results if recommended in the package insert.

☐ ECOG performance status score and medical necessity of treatment with ECOG score of 4

For prior authorization renewal requests, the prescriber must submit the following:

☐ Current chart notes

☐ Current lab work

☐ Current weight or body surface area

☐ Dose requested

☐ Documentation of current response to treatment

☐ Attestation that the patient exhibits a positive response from treatment without intolerable side effects.

Initial requests may be approved for 3 months, unless otherwise noted, with renewal pending a positive response to treatment without intolerable side effects. Prior authorization renewals may be approved for 3–6 months depending on the level of monitoring required for the treatment.

☐ Attachments

Prescriber Signature: _____ **Date:** _____

(Required) Prescriber's original signature required; copied, stamped, or e-signature is not allowed. This certifies that the information provided in the Statement of Medical Necessity is accurate and substantiated by the patient's medical record.

Fax this form to 800-424-5851