# Lysodren (mitotane)
## Prior Authorization Request Form
Caterpillar Prescription Drug Benefit
Phone: 877-228-7909  Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

## MEMBER INFORMATION

| | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PHONE NUMBER:** | **DATE OF BIRTH:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:**    **ZIP CODE:** |
| **PATIENT INSURANCE ID NUMBER:** | |

☐ MALE  ☐ FEMALE   HEIGHT (IN/CM): _____   WEIGHT (LB/KG): _____   ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** _____

**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** _____

## PRESCRIBER INFORMATION

| | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PRESCRIBER SPECIALTY:** | **EMAIL ADDRESS:** |
| **NPI NUMBER:** | **DEA NUMBER:** |
| **PHONE NUMBER:** | **FAX NUMBER:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:**    **ZIP CODE:** |
| **REQUESTOR** (if different than prescriber)**:** | **OFFICE CONTACT PERSON:** |

## MEDICATION  OR MEDICAL DISPENSING INFORMATION

| **MEDICATION NAME:** | | | |
|---|---|---|---|
| **DOSE/STRENGTH:** | **FREQUENCY:** | **LENGTH OF THERAPY/REFILLS:** | **QUANTITY:** |
| ☐ **NEW THERAPY** | ☐ **RENEWAL** | **IF RENEWAL:** DATE THERAPY INITIATED: | |
| DURATION OF THERAPY (SPECIFIC DATES): | | | |

*Continued on next page.*

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### Phone: 877-228-7909  Fax: 800-424-7640

**MEMBER'S LAST NAME:** _____   **MEMBER'S FIRST NAME:** _____

| 1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO |||
|---|---|---|
| **MEDICATION/THERAPY** (SPECIFY DRUG NAME AND DOSAGE)**:** | **DURATION OF THERAPY** (SPECIFY DATES)**:** | **RESPONSE/REASON FOR FAILURE/ALLERGY:** |
| | | |

| 2. LIST DIAGNOSES: | ICD-10: |
|---|---|
| ☐ Cushing's syndrome secondary to pituitary disorders<br>☐ Inoperable adrenal cortical carcinoma (functional and nonfunctional types)<br>☐ Other diagnosis: _____ICD-10: _____ | |

**3. REQUIRED CLINICAL INFORMATION:** PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

**For <u>Cushing's syndrome secondary to pituitary disorders</u>, answer the following:**

**Is the patient using Lysodren as a postoperative treatment after incomplete resection? ☐ Yes ☐ No**

**Will Lysodren be used in combination with radiation? ☐ Yes ☐ No**

<u>Reauthorization:</u>

**If this is a reauthorization request, answer the following question:**
**Has the patient experienced a positive tumor response with stabilization of disease or decrease in size of tumor or tumor spread?* ☐ Yes ☐ No**
*Please submit documentation.*

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** _____ **Date:** _____

### FAX THIS FORM TO: 800-424-7640
**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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