Xalkori (crizotinib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

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

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** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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CAT0280

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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:**
□ Non-small cell lung cancer (NSCLC) □ Inflammatory Myofibroblastic Tumor(IMT) □ Other diagnosis: _____ICD-10_____	

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

Clinical Information:
Is Xalkori(crizotinib) going to be used in conjunction with a clinical trial? □ Yes □ No

<u>For non-small cell lung cancer(NSCLC), please answer the following:</u>
Does the patient have a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC)? □ Yes □ No

Is the patient positive for anaplastic lymphoma kinase (ALK) as detected by an FDA-approved test?* □ Yes □ No
Please provide the physician chart notes or lab report confirming ALK-positive status.

Has the patient had prior treatment with another kinase inhibitor such as Zykadia (ceritinib), Alecensa (alectinib), or Alunbrig (brigatinib)? □ Yes □ No

<u>For inflammatory myofibroblastic tumor(IMT), please answer the following</u>:
Does the patient have a diagnosis of unresectable, recurrent or refractory inflammatory myofibroblastic tumor(IMT)? □ Yes □ No *Please submit chart notes*.

Is the tumor ALK-positive? □ Yes □ No *Please provide the physician chart notes or lab report confirming ALK-positive status.*

Has the patient been previously treated with crizotinib or another ALK inhibitor such as ceritinib(Zykadia), alectinib(Alcensa), brigatinib(Alunbrig), or lorlatinib(Lobrena)? □ Yes □ No

Will the patient use crizotinib as monotherapy? □ Yes □ No

Does the patient have malignant meningitis or leptomeninges? □ Yes □ No

Does patient have tumors in the brain? □ Yes □ No

If patient has tumors in the brain, is patient taking corticosteroids? □ Yes □ No
If patient is taking corticosteroids, will they be discontinued when starting crizotinib? □ Yes □ No

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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/diagnoses 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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