

Erivedge (vismodegib) 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.

| | | | | U | JRGENT |
|--|------------------------|------------------------|-----------------------------|---|--------|
| MEMBER INFORMATION | | | | | |
| LAST NAME: | | | FIRST NAME: | | |
| PHONE NUMBER: | | | DATE OF BIRTH: | : | |
| STREET ADDRESS: | | | | | |
| CITY: | | | STATE: | ZIP CODE: | |
| PATIENT INSURANCE ID N | IUMBER: | | l | | |
| MALE FEMALE H | EIGHT (IN/CM): | WEIGH | НТ (LB/KG): | ALLERGIES: | |
| IF YOU ARE NOT THE PATIENT OR THE PRE FOLLOWING LINK: <u>HTTPS://MAGELLANRX</u> | | | | RM WITH THIS REQUEST WHICH CAN BE FOUND AT THE OSURE AUTHORIZATION.PDF | į |
| PATIENT'S AUTHORIZED RI AUTHORIZED REPRESENTA | - | - | | | |
| PRESCRIBER INFORMATION | ON | | | | |
| 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 MEDICA | AL DISPENSING INFOR | RMATION | | | |
| MEDICATION NAME: | | | | | |
| DOSE/STRENGTH: | FREQUENCY: | | LENGTH OF THERAPY/REFILL | QUANTITY: LS: | |
| NEW THERAPY DURATION OF THERAPY (S | RENEW SPECIFIC DATES): | /AL | IF RENEWAL: DA | ATE THERAPY INITIATED: | |
| Continued on next page. | | | | | |

© 2017 – 2023 by Magellan Rx Management, LLC. All Rights Reserved.

Revision Date: 08/22/2018

CAT0077







Erivedge (vismodegib) Prior Authorization Request Form



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

| PRESENTION? YES (if yes, complete below) NO HERAPY (SPECIFY RESPONSE/REASON FOR FAILURE/ALLERGY: ICD-10: ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A sonidegib)? Yes No intolerance to adverse effects?* Yes No insufficient tumor response? Yes No sponse, intolerance, or contraindication to the following |
|---|
| HERAPY (SPECIFY RESPONSE/REASON FOR FAILURE/ALLERGY: ICD-10: ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A sonidegib)? □ Yes □ No intolerance to adverse effects?* □ Yes □ No insufficient tumor response?□ Yes □ No |
| sonidegib)? Yes No intolerance to adverse effects?* Yes No insufficient tumor response? Yes No |
| sonidegib)? Yes No intolerance to adverse effects?* Yes No insufficient tumor response? Yes No |
| sonidegib)? Yes No intolerance to adverse effects?* Yes No insufficient tumor response? Yes No |
| intolerance to adverse effects?* □ Yes □ No insufficient tumor response?□ Yes □ No |
| · |
| sponse, intolerance, or contraindication to the following |
| |
| g questions: t least 30 percent since starting Erivedge therapy?* Yes |
| sonidegib)?□ Yes □ No medications tried or failed, and/or any other information the |
| (: |

© 2017 – 2023 by Magellan Rx Management, LLC. All Rights Reserved.

Revision Date: 08/22/2018

CAT0077







Erivedge (vismodegib) Prior Authorization Request Form



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

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 I | lectronic I.D. | Verification: |
|---------------------------|----------------|---------------|
|---------------------------|----------------|---------------|

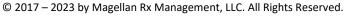
Date:

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

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



Revision Date: 08/22/2018

CAT0077



