Blastic Plasmacytoid Dendritic Cell Neoplasm
Elzonris (tagraxofusp-erzs) J9269
Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

- ☐ Patient is 2 years of age or older; AND
- ☐ Patient has a diagnosis of blastic plasmacytoid dendritic cell neoplasm (BPDCN); AND
- ☐ Patient has a current Eastern Cooperative Oncology Group (ECOG) status of 0-1; AND
- ☐ Patient is using as monotherapy; AND
- ☐ At initial therapy, Patient has a baseline serum albumin of 3.2 g/dL or higher .

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ Patient had an adequate response or significant improvement while on this medication.
If not, please provide clinical rationale for continuing this medication: _____
_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Blastic Plasmacytoid Dendritic Cell Neoplasm Drugs PA

Drug Name(s):
ELZONRIS **TAGRAXOFUSP-ERZS**

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:
N/A

Age Restrictions:
2 years old and above

Prescriber Restrictions:
Hemotology, Oncology or related specialist

FDA Indications:
Elzonris:

- Blastic plasmacytoid dendritic cell neoplasm

Off-Label Uses:
N/A

Coverage Duration:
Approval will be determined on an individual basis

Other Clinical Consideration:
Black Box Warning:

- Capillary Leak Syndrome (CLS) which may be life-threatening or fatal, can occur in patients receiving tagraxofusp-erzs. Monitor for signs and symptoms of CLS and take actions as recommended

Resources:
https://www.micromedexsolutions.com/micromedex2/librarian/CS/9BB081/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/FF1EC3/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=932611&contentSetId=100&title=Tagraxofusp-erzs&servicesTitle=Tagraxofusp-erzs&brandName=Elzonris&UserMdxSearchTerm=Elzonris&=null#