ATRIO HEALTH PLANS

Neuroblastoma (Pediatric)
Unituxin (dinutuximab) J1246
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

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

- ☐ Less than 18 years of age
- ☐ Will use in combination with granulocyte-macrophage colony-stimulating factor, interleukin-2, and 13-cis-retinoic acid
- ☐ Demonstrated at least a partial response to induction combination chemotherapy and maximum feasible surgical resection
- ☐ Previous myeloablative consolidation chemotherapy followed by autologous stem cell transplantation and radiation therapy to residual soft tissue disease

☐ **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 – Unituxin PA

Drug Name(s):

UNITUXIN **DINUTUXIMAB**

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

Prescriber Restrictions:

Pediatric Neurologist or another related specialist

Coverage Duration:

Initial Approval will be for 6 months
Continuation will be approved for 12 months

FDA Indications:

Unituxin

- Neuroblastoma

Off-Label Uses:

N/A

Age Restrictions:

18 years and YOUNGER.

Other Clinical Consideration:

N/A

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/F151F0/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/D960ED/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=933966&contentSetId=100&title=Velmanase+Alfa-tycv&servicesTitle=Velmanase+Alfa-tycv&brandName=Lamzede&UserMdxSearchTerm=Lamzede&=null#