univera HEALTHCARE

Specialty Medication Review Program

Oncology Biosimilar Drugs
Alymsys, Avastin, Herceptin, Herceptin Hylecta, Herzuma, Ogivri, Ontruzant, Riabni, Rituxan, Rituxan Hycela, & Vegzelma

Complete this form and fax to:

☐ **Medical Specialty Unit**
Fax: 1-800-306-0188
Phone: 1-800-499-1275

If you are not **buying and billing** this medication, indicate which specialty pharmacy will be used:

☐ **Accredo Health**
Fax: 1-888-773-7386
Phone: 1-866-413-4137

☐ **AllianceRx Walgreens Pharmacy**
Fax: 1-866-435-2173
Phone: 1-866-435-2171

☐ **Noble**
Fax: 1-888-842-3977
Phone: 1-888-843-2040

Complete ALL the following Patient/Prescriber Information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #	Patient Birthdate:
List Patient Allergy (If Any)	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:
Location of Infusion: ☐ **Prescriber office** ☐ **Home/Homecare agency:**_____ ☐ **Outpatient facility:** ☐ **Other:** _____	
Servicing Prescriber NPI (if different from the ordering prescriber):	
Provide address of infusion location above for medication shipping:	

Medication/Medical and Dispensing Information

NOTE: For all NEW STARTS, treatment with a **preferred product is required** unless there is adequate medical justification as to **why the preferred products cannot be used**. Documentation of adequate medical justification **MUST** be submitted with this request.
**** The preferred products DO NOT require prior authorization ****

**** See the Oncology Biosimilar Drug Policy (Pharmacy-93) for full Prior Authorization criteria ****

Indicate Medication Being Requested	Preferred Product(s) *No Prior Authorization (PA) Required*
☐ Avastin (bevacizumab) - J9035 ☐ Alymsys (bevacizumab-maly) – Q5126 ☐ Vegzelma (bevacizumab-adcd) – Q5129 ***Prior Authorization is not required when treating the EYE***	Mvasi (bevacizumab-awwb) – Q5107 Zirabev (bevacizumab-bvzr) – Q5118
☐ Herceptin (trastuzumab) – J9355 ☐ Herceptin Hylecta (trastuzumab/hyaluronidase-oysk) – J9356 ☐ Herzuma (trastuzumab-pkrb) – Q5113 ☐ Ogivri (trastuzumab-dkst) – Q5114 ☐ Ontruzant (trastuzumab-dttb) – Q5112	Trazimera (trastuzumab-qyyp) – Q5116 Kanjinti (trastuzumab-anns) – Q5117
☐ Rituxan (rituximab) – J9312 ☐ Rituxan Hycela (rituximab/ hyaluronidase) – J9311 ☐ Riabni (rituximab-arrx) – Q5123	Ruxience (rituximab-pvvr) – Q5119 Truxima (rituximab-abbs) – Q5115

Dose	Frequency	Height	Weight (lbs. or kg)	Procedure Code

Diagnosis/ICD-10:

Is this request for a: ☐ **New Start** **OR** ☐ **Continuation of Therapy (recertification)? Start Date:** _____

Questions/Indications for Medical Necessity

**** See the Oncology Biosimilar Drug Policy (Pharmacy-93) for full Prior Authorization criteria ****

1. When was the patient **initially diagnosed**?
2. Is the requested medication being requested as **initial (first line) therapy**? ☐ **Yes** ☐ **No**
3. What therapy is the requested medication being used in combination with?
4. If not initial therapy, provide **previous therapies** utilized:
   a. Drug/ Drug combination: _____ From: _____ To: _____
   b. Drug/ Drug combination: _____ From: _____ To: _____

☐ Check this box if you are requesting an exception to New York State Step therapy law (Insurance Law 4903) (if applicable to your patient). The reason(s) you are requesting an exception to a trial of the preferred drug(s) must be clear (i.e., the reason(s) must reflect one or more points of the law). Clinical rationale and documentation supporting the exception(s) requested must be submitted.

ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST.

Prescriber signature:_____ Date:_____

I certify the above information is true and accurate to the best of my knowledge.