{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the diagnosis?
   - ❑ Non-small cell lung cancer (NSCLC)
   - ❑ Inflammatory myofibroblastic tumor (IMT)
   - ❑ Erdheim-Chester disease
   - ❑ Diffuse large B-cell lymphoma
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. The preferred products for your patient's health plan are Alecensa and Alunbrig. Can the patient's treatment be switched to a preferred product? ***If Yes, fax a new prescription to pharmacy and no further questions.***
   ❑ Yes - Alecensa ❑ Yes - Alunbrig ❑ No - Continue request for Lorbrena
4. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #6*
5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? ❑ Yes ❑ Unknown ❑ No *If No, skip to #7*
6. Does the patient have a documented intolerable adverse event or documented inadequate responseto treatment with the preferred products (Alecensa, Alunbrig)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** *Indicate all that apply.*
   ❑ Alecensa ❑ Intolerable adverse event ❑ Documented inadequate response
   ❑ Alunbrig ❑ Intolerable adverse event ❑ Documented inadequate response
7. I*f the diagnosis is non-small cell lung cancer (NSCLC) or Diffuse large B-Cell Lymphoma,* what is the clinical setting in which the requested medication will be used?
   - ❑ Advanced disease
   - ❑ Metastatic disease (including brain metastases from NSCLC)
   - ❑ Recurrent disease
   - ❑ Refractory disease
   - ❑ Relapsed disease
   - ❑ Other _____
   - ❑ N/A, diagnosis is not Non-small cell lung cancer (NSCLC) or Diffuse large B-Cell Lymphoma
8. Will the requested medication be used as a single agent? ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Non-Small Cell Lung Cancer (NSCLC)

1. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #3*
2. Is there evidence of unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No *No further questions.*
3. Is the disease anaplastic lymphoma kinase (ALK)-positive? ***ACTION REQUIRED: If Yes, attach chart documentation or test results of ALK mutation status.*** ❑ Yes ❑ No ❑ Unknown
4. Is the disease ROS1 rearrangement-positive? ***ACTION REQUIRED: If Yes, attach chart documentation or test results of ROS1 rearrangement status.*** ❑ Yes ❑ No ❑ Unknown
5. Has the disease progressed on any of the following therapies?
   ❑ Ceritinib ❑ Crizotinib ❑ Entrectinib ❑ None of the above

Inflammatory Myofibroblastic Tumor (IMT), Erdheim-Chester Disease or Diffuse Large B-Cell Lymphoma

1. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #3*
2. Is there evidence of unacceptable toxicity or diesease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions.*
3. Is the tumor anaplastic lymphoma kinase (ALK)-positive? ***ACTION REQUIRED: If yesYes, attach chart documentation or test results of ALK mutation status.*** ❑ Yes ❑ No ❑ Unknown

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date