



Clolar
Clolar (clofarabine) J9027
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.

<input type="checkbox"/>	Standard Request– (72 Hours)	<input type="checkbox"/>	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

- 15 mg/m(2)/day IV over 1 hour on days 1 through 3, for up to 6 cycles with cycles repeated every 4 to 6 weeks
- 20 mg/m(2) IV once daily for 5 days with cycles repeated every 4 to 6 weeks
- 40 mg/m(2)/day administered IV over 1 hour for 5 consecutive days every 3 to 6 weeks
- 52 mg/m(2)/day IV over 2 hours for 5 consecutive days; repeat every 2 to 6 weeks
- Other Regimen _____

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)

Acute lymphoid leukemia, Relapsed or refractory

- Medical record documentation of a minimum of two prior treatment regimens **AND**
- single agent **OR**
- part of a multi-agent regimen (e.g., clofarabine + cyclophosphamide + etoposide).

Acute myeloid leukemia

- Medical record documentation of a minimum of two prior treatment regimens **AND**
- single agent **OR**
- part of a multi-agent regimen (e.g., clofarabine + cytarabine +/- idarubicin).

Leukemia

- Medical record documentation of a minimum of two prior treatment regimens **AND**
- single agent **OR**
- part of a multi-agent regimen (e.g., clofarabine + cytarabine +/- idarubicin).

If not, please provide **clinical rationale** for formulary exception: _____

Continuation Requests: (Clinical documentation required for all requests)

- Patient had an **adequate response** or **significant improvement** while on this medication.
- Medical record documentation of positive response is included

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 – Clolar Prior Authorization

Drug Name(s):

CLOLAR

CLOFARABINE

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.
 - Continuation Requests: Provider must verify continued clinical benefit in confirmatory trial(s).

Exclusion Criteria:

N/A

Prescriber Restrictions:

Oncologist or other Leukemia specialist

Coverage Duration:

Approval will be for 6 months

FDA Indications:

Clolar

- Acute lymphoid leukemia, Relapsed or refractory

Off-Label Uses:

- Acute myeloid leukemia
- Leukemia

Age Restrictions:

Indicated for patients 2 years or older.

Other Clinical Consideration:

N/A

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/250797/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/EA6630/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=928356&contentSetId=100&title=Clofarabine&serviceTitle=Clofarabine&brandName=Clolar+Novaplus&UserMdxSearchTerm=Clolar#