ATRIO
HEALTH PLANS

Xipere
Xipere (triamcinolone acetonide) J3299
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 has a diagnosis of noninfectious uveitis; AND
　☐ Patient has evidence of macular edema secondary to uveitis

　　• **Vyvgart Hytrulo may not be Individual has active or suspected ocular or periocular infections including most viral diseases of cornea and conjunctiva including active epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, varicella, mycobacterial infections, and fungal disease;**

　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.

　　If not, please provide clinical rationale for continuing this medication: _____
　　_____

For questions or assistance, please contact Customer Service at 1-877-672-8620, daily, 8am – 8pm (PST) (TTY users should call 1-800-735-2900).

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 – Xipere Prior Authorization

Drug Name(s):
XIPERE   **TRIAMCINOLONE ACETONIDE INJ**

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 in accordance with the label.

Exclusion Criteria:
N/A

Prescriber Restrictions:
N/A

Coverage Duration:
Approval will be for 12 months

FDA Indications:
Xipere
- Acquired hemolytic anemia
- Allergic rhinitis, Perennial or seasonal
- Asthma
- Collagen disease
- Disorder of endocrine system
- Disorder of eye
- Disorder of gastrointestinal tract
- Disorder of respiratory system
- Disorder of skin
- Ganglion cyst, of synovium, tendon and bursa
- Gout, acute, Short-term to tide patient over acute episode or exacerbation; Adjunct
- Inflammatory disorder of musculoskeletal system, Short-term to tide patient over acute episode or exacerbation; Adjunct
- Leukemia
- Malignant lymphoma
- Multiple sclerosis
- Nephrotic syndrome, Idiopathic or lupus erythematosus-induced
- Osteoarthritis of knee - Pain
- Stomatitis

Age Restrictions:
N/A

Other Clinical Consideration:
N/A

Resources:
https://www.micromedexsolutions.com/micromedex2/librarian/PFDefaultActionId/evidencexpert.DoIntegratedSearch?SearchTerm=xipere&UserSearchTerm=xipere&SearchFilter=filterNone&navitem=searchGlobal#

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