



Chemotherapy: Fulvestrant Products

Faslodex (fulvestrant) J9395, Teva (fulvestrant) J9393,
Fresenius Kabi (fulvestrant) J9394

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

HCP Code	Name of Drug	Dose (Wt: _____ kg Ht: _____)	Frequency	End Date if known

500 mg IM on days 1, 15, 29, and once monthly thereafter
 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)
 Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.
If not, please provide clinical rationale for formulary exception: _____

Continuation Requests: (Clinical documentation required for all requests)
 Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.
 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 – Oncology: Fulvestrant Products PA

Drug Name(s):

FULVESTRANT

FASLODEX

TEVA

FRESENIUS KABI

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Prescribed by, or in consultation with an oncologist or other cancer specialist related to the diagnosis.
3. Drug is being used appropriately per CMS recognized compendia, authoritative medical literature, evidence based guidelines and/or accepted standards of medical practice.
4. 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:

Cannot be prescribed for experimental or investigational use.

Prescriber Restrictions:

Oncologist or other cancer specialist

Coverage Duration:

New Start: Approval will be for 6 months

Continuation: Approval will be for 12 months

FDA Indications:

All Products

- Breast cancer, Advanced, hormone receptor-positive, HER2-negative disease, in postmenopausal women not previously treated with endocrine therapy, monotherapy.
- Breast cancer, Advanced, hormone receptor-positive, postmenopausal with disease progression following endocrine therapy, monotherapy
- Breast cancer, Advanced or metastatic, HER2-negative, hormone receptor-positive, in combination with abemaciclib for disease progression following endocrine therapy
- Breast cancer, Advanced or metastatic, HER2-negative, hormone receptor-positive, in combination with palbociclib for disease progression following endocrine therapy
- Breast cancer, Metastatic or advanced, HER-2 negative, hormone receptor-positive disease in postmenopausal women; in combination with ribociclib as initial endocrine-based therapy or following disease progression on endocrine therapy

Off-Label Uses:

N/A

Age Restrictions:

Safety and efficacy not established in pediatric patients

Other Clinical Considerations:

Cancer diagnoses: Criteria as per NCCN or other FDA-approved cancer related guidelines.



Part B Prior Authorization Guidelines

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/97C122/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/D90726/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=926965&contentSetId=100&title=Fulvestrant&servicesTitle=Fulvestrant&brandName=Faslodex&UserMdxSearchTerm=Faslodex#

CLINICAL / CMS
ONLY