Welireg (belzutifan)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ **Tumor associated with von Hippel Lindau disease (VHL)** ☐ **Renal Cell Carcinoma(RCC)** ☐ **Renal Cell Carcinoma with clear cell component** ☐ **Other diagnosis:** _____ **ICD-10 Code(s):**	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

<u>For von Hippel Lindau disease, answer the following:</u>
Does patient have a tumor associated with von Hippel Lindau disease(VHL)? □ Yes □ No Please submit documentation.

Has patient been previously treated with belzutifan (Welireg) or another HIF-2alpha inhibitor or any other systemic anti-cancer agents? □ Yes □ No Please submit documentation.

Does patient have an immediate need for surgical intervention for tumor treatment; defined as surgery needed within 60 days of starting belzutifan (Welireg)? □ Yes □ No Please submit documentation.

Does patient have metastatic disease? □ Yes □ No

<u>For renal cell carcinoma, please answer the following</u>:
Does patient have diagnosis of unresectable, locally advanced or metastatic clear cell renal cell carcinoma (RCC)? □ Yes □ No Please submit documentation.

Has patient had disease progression on or after having received systemic treatment for locally advanced or metastatic RCC with a Programmed cell death 1 ligand 1 (PD-1/L1) checkpoint inhibitor, such as pembrolizumab(Keytruda), nivolumab(Opdivo), or cemiplimab(Libtayo)? □ Yes □ No Please submit documentation.

Has patient had disease progression on or after having received systemic treatment for locally advanced or metastatic RCC with a vascular endothelial growth factor - tyrosine kinase inhibitor (VEGF-TKI), such as bevacizumab (Avastin), sorafenib (Nexavar), sunitinib (Sutent), nilotinib (Tasigna), pazopanib (Votrient), and dasatinib (Sprycel), gefitinib(Iressa), erlotinib(Tarceva) in sequence or in combination? □ Yes □ No Please submit documentation.

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Has patient received more than 3 prior systemic regimens for locally advanced or metastatic RCC? □ Yes □ No Please submit documentation.

Does patient have known central nervous system (CNS) metastases and/or carcinomatous meningitis? □ Yes □ No Please submit documentation.

If patient has been previously treated for brain metastases, have they been radiologically stable for at least 4 weeks (28 days) by repeat imaging)? □ Yes □ No Please submit documentation.

Has patient received prior treatment with belzutifan or another hypoxia inducible factor 2α (HIF-2α inhibitor)? □ Yes □ No Please submit documentation.

Has patient received prior treatment with everolimus or any other specific or selective target of rapamycin complex 1 (TORC1)/ phosphatidylinositol 3-kinase (PI3K)/ protein kinase B (AKT) inhibitor (e.g., temsirolimus) in the advanced disease setting? □ Yes □ No Please submit documentation.

<u>For diagnosis of renal cell carcinoma with clear cell component, please answer the following</u>:
Does patient have a diagnosis of renal cell carcinoma with a clear cell component? □ Yes □ No Please submit documentation.

Will patient use Welireg(bezultifan) in combination with pembrolizumab(Keytruda) or pembrolizumab(Keytruda) and berahyaluronidase alfa-pmph? □ Yes □ No Please submit documentation.

Will the above combination be used for adjuvant treatment? □ Yes □ No Please submit documentation.

Is patient at intermediate-high or high risk of recurrence following a nephrectomy or following a nephrectomy and resection of metastatic lesions? □ Yes □ No Please submit documentation.

Does patient have an ECOG score of 0-1? □ Yes □ No

Has patient received prior systemic therapy for RCC? □ Yes □ No Please submit documentation.

Has patient received radiotherapy for RCC? □ Yes □ No Please submit documentation.

<u>For diagnois of pheochromocytoma or paraganglioma, please answer the following</u>:
Does patient have a diagnosis of locally advanced, unresectable, or metastatic pheochromocytoma or paraganglioma(PPGL)? □ Yes □ No *Please submit documentation demonstrating diagnostic and therapeutic testing that patient has PPGL.*

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909

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