

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:
<input type="checkbox"/> NEW THERAPY <input type="checkbox"/> 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?		
<input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Tumor associated with von Hippel Lindau disease (VHL) <input type="checkbox"/> Renal Cell Carcinoma(RCC) <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<u>For von Hippel Lindau disease, answer the following:</u> Does patient have a tumor associated with von Hippel Lindau disease(VHL)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit documentation.		
Has patient been previously treated with belzutifan (Welireg) or another HIF-2alpha inhibitor or any other systemic anti-cancer agents? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit documentation.		
Does patient have metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit documentation.		
Has patient received more than 3 prior systemic regimens for locally advanced or metastatic RCC? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit documentation.		



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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 2 α (HIF-2 α 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.

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

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
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St. Paul, MN 55164-0811
Phone: 877-228-7909