Temodar (temozolomide)
Prior Authorization Request Form

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

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:**
REQUESTOR (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** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

Continued on next page.

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

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:**
□ Glioblastoma multiforme (GBM) □ Anaplastic Astrocytoma/high-grade glioma □ Primary CNS lymphoma □ Metastatic melanoma □ GD2 Wild Type Oligodendroglioma □ Other diagnosis: _____ICD-10_____	

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

What is the patient's body surface area (units in m2)?
Please document: _____

Will patient use in conjunction with a clinical trial? □ Yes □ No Please submit documentation.

<u>Glioblastoma multiforme OR Anaplastic Astrocytoma/high-grade glioma:</u>
Will the medication be used in combination with radiotherapy for induction treatment? □ Yes □ No Please submit documentation.

Will the medication be used for maintenance therapy? □ Yes □ No Please submit documentation.

<u>GD2 Wild Type Oligodendroglioma:</u>
Will the medication be used in combination with radiotherapy for induction treatment? □ Yes □ No Please submit documentation.

Will the medication be used for maintenance therapy? □ Yes □ No Please submit documentation.

<u>For Recurrent Anaplastic Astrocytoma</u>:
Does patient have recurrent disease? □ Yes □ No Please submit documentation.

Will Temodar(temozolomide) be used as a single agent or in combination with bevacizumab? □ Yes □ No Please submit documentation.

Will Temodar(temozolomide) be used as adjuvant treatment for patients with KPS ≥ 60 (i.e., ECOG 0-2) as a single agent either concurrently or following standard radiation therapy? □ Yes □ No Please submit documentation.

Does patient have refractory Anaplastic Astrocytoma and will use Temodar(temozolomide) as a single agent for disease progression on a nitrosourea and procarbazine-containing regimen? □ Yes □ No Please submit documentation.

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Is patient newly diagnosed Anaplastic Astrocytoma? □ Yes □ No Please submit documentation.

Was patient previously treated with radiation? □ Yes □ No Please submit documentation.

<u>For Central Nervous System (CNS) Cancer – Oligodendroglioma- WHO Grade II:</u>
Will Temodar(temozolomide) be **used as adjuvant treatment as a single agent either concurrently or following radiation therapy? □ Yes □ No Please submit documentation.**

Does patient have presence of sequencing verified IDH wild type? □ Yes □ No Please submit documentation.

<u>Renewal Therapy</u>
Has there been a positive tumor response (i.e., decreased size, spread) and has the patient's disease stabilized?
□ Yes □ No
Please submit documentation

What is the patient's body surface area (units in m2)?
Please document: _____

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
P.O. Box 64811
St. Paul, MN 55164-0811

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