ATRIO HEALTH PLANS

Camcevi

Camcevi (leuprolide injectable) J1952

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)**

☐ Prostate cancer, as indicated by **1 or more** of the following:
- ☐ Intermediate-risk, high-risk, or very high-risk disease, as indicated by **1 or more** of the following:
  - ☐ Intern'l Society of Urological Pathology (ISUP) Grade Group 2 to 5 (Gleason score: 7 to 10)
  - ☐ Pretreatment PSA of 10 ng/mL (mcg/L) or greater
  - ☐ Stage T2b/T2c, stage T3a/T3b, or stage 4 prostate cancer
- ☐ Metastatic prostate cancer (ie, bone or other metastasis)
- ☐ Post radical prostatectomy with adverse laboratory, histologic, or biopsy features, as indicated by **1 or more** of the following:
  - ☐ Extracapsular extension of tumor
  - ☐ Invasion of seminal vesicle
  - ☐ Lymph node metastasis
  - ☐ Positive biopsy margin(s)
  - ☐ PSA detectable

☐ Breast cancer, with **1 or more** of the following:

- ☐ Adjuvant therapy needed,[A] and **ALL** of the following:
  - ☐ Administered in combination with tamoxifen or an aromatase inhibitor (eg, exemestane)
  - ☐ Patient is premenopausal.
  - ☐ Tumor is estrogen receptor positive or progesterone receptor positive.
- ☐ Advanced disease,[B] and **ALL** of the following:
  - ☐ Palliative treatment
  - ☐ Patient is premenopausal or perimenopausal.
- ☐ Prevention of premature ovarian failure needed, and **ALL** of the following:
  - ☐ Patient is receiving cytotoxic agent associated with premature ovarian failure (eg, cyclophosphamide).
  - ☐ Patient is premenopausal.

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: _____
_____

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 – Camcevi PA

Drug Name(s):

CAMCEVI **LEUPROLIDE INJECTABLE**

Criteria for approval of Prior Authorization 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.

Exclusion Criteria:

- Hypersensitivity to leuprolide, gonadotropin releasing hormone (GnRH), GnRH agonists or any of the excipients in the formulations
- Pregnancy
- Undiagnosed and abnormal uterine bleeding

Prescriber Restrictions:

N/A

Coverage Duration:

Initial approval will be for 6 months. Continuation may be approved for up to 12 months.

FDA Indications:

Camcevi

- Prostate Cancer, Advanced

Off-Label Uses:

- Breast Cancer
- Gender Dysphoria – Transgender female; Adjunct
- Ovarian Cancer
- Prostate Cancer, Localized
- Prostate Cancer, Neoadjuvant treatment
- Uterine Leiomyoma
- Thyroid eye disease (Moderate to Severe), Active

Age Restrictions:

2 years and older

Other Clinical Considerations:

N/A

Resources:

https://careweb.careguidelines.com/ed28/ac/ac04_007.htm#top