Alecensa® (alecetinib)

PRIOR AUTHORIZATION REQUEST FORM

For authorization, **please answer each question, include patient chart notes to document clinical information, and fax this form back to the PEHP Prior Authorization Department at (801) 245-7774** or mail to: PEHP Pharmacy services, 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization questions, you may phone the PEHP Customer Service at (801) 366-7551.

Chart notes are required for review

1. Date: Click or tap to enter a date.	2. Patient Name:	3. ID #:
4. D.O.B:	5. Physician:	6. Office Phone:
7. Office Fax:	8. Office Contact:	9. Dose Request:
10. Sex:	11. Weight:	

Authorization is requested from: / / to / /

Question	Yes	No	Comments/Notes
12. Is the prescribing provider an oncologist?			
13. Will Alecensa® be given in combination with other chemotherapy agents?			
14. Indicate the patient's ECOG performance status:	ECOG performance:		
15. Select the patient's diagnosis: ☐ Non-Small Cell Lung Cancer (NSCLC) ☐ Other*(list):			*Include clinical studies, other supporting literature, and chart notes for all other indications.
16. If the diagnosis is NSCLC, is it ALK positive?			
17. Is the cancer locally advanced or metastatic?			
18. Has the patient received previous treatment with Xalkori®?			
19. If 'yes' to 18, has the patient demonstrated intolerance or progression while on therapy?			
20. Has the patient had previous therapy with Alecensa®?			
21. If 'yes' to 21, is there evidence of clinical improvement from the pre-treatment report or stable disease through clinical assessment, imaging, or laboratory analysis?			Documentation is required.

PEHP restricts coverage of Alecensa® to the specialty pharmacy Accredo, ONLY.

22. Physician's signature: ______________________________

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