Antineoplastic Review

June 4th, 2007
Heritage Center
Rooms A and B
1pm

north dakota
department of
human services

Oral Antineoplastic Utilization (AHFS Class 100000)

NDC USAGE for nd_antineoplastics from 03/01/06 to 02/26/07 for Program All				
NDC Code	**Rx Num**	**Qty Dispensed**	**Total Claim Cost**	**Label Name**
93078406	18	1098	$735.15	TAMOXIFEN 10 MG TABLET
555088202	21	1410	$951.35	HYDROXYUREA 500 MG CAPSULE
15050842	2	810	$629.50	MEGACE 40 MG/ML ORAL SUSP
49884029001	4	140	$134.08	MEGESTROL 40 MG TABLET
555060702	5	385	$378.01	MEGESTROL 40 MG TABLET
904174960	18	642	$634.85	METHOTREXATE 2.5 MG TABLET
555090401	12	360	$378.64	TAMOXIFEN 20 MG TABLET
172565760	40	1200	$1,336.34	TAMOXIFEN 20 MG TABLET
49884072401	30	1870	$2,124.57	HYDROXYUREA 500 MG CAPSULE
49884029004	13	1290	$1,466.36	MEGESTROL 40 MG TABLET
67253032010	9	182	$230.34	METHOTREXATE 2.5 MG TABLET
172565649	3	150	$196.54	TAMOXIFEN 10 MG TABLET
555057202	150	3829	$5,199.46	METHOTREXATE 2.5 MG TABLET
378027401	2	60	$86.74	TAMOXIFEN 20 MG TABLET
54455025	81	2221	$3,677.30	METHOTREXATE 2.5 MG TABLET
378001401	71	1803	$3,179.61	METHOTREXATE 2.5 MG TABLET
378014491	4	240	$476.60	TAMOXIFEN 10 MG TABLET
172496058	4	285	$613.30	FLUTAMIDE 125 MG CAPSULE
54483422	1	30	$66.10	TAMOXIFEN 20 MG TABLET
378027493	20	600	$1,468.18	TAMOXIFEN 20 MG TABLET

555090414	42	1260	$3,303.60	TAMOXIFEN 20 MG TABLET
49884092202	32	1723	$5,535.61	MERCAPTOPURINE 50 MG TABLET
54458111	1	100	$331.25	MERCAPTOPURINE 50 MG TABLET
54458127	23	761	$2,569.55	MERCAPTOPURINE 50 MG TABLET
4110051	4	196	$748.66	XELODA 150 MG TABLET
54413025	1	28	$130.55	CYCLOPHOSPHAMIDE 50 MG TAB
4110020	3	84	$446.19	XELODA 150 MG TABLET
173088025	3	52	$332.82	THIOGUANINE TABLOID 40 MG TB
310020130	177	5310	$48,875.90	ARIMIDEX 1 MG TABLET
78024915	65	1950	$18,807.29	FEMARA 2.5 MG TABLET
9766304	17	510	$4,968.87	AROMASIN 25 MG TABLET
85124801	3	15	$154.29	TEMODAR 5 MG CAPSULE
85124802	2	14	$144.45	TEMODAR 5 MG CAPSULE
4110116	2	196	$2,585.63	XELODA 500 MG TABLET
310070530	6	165	$2,811.80	CASODEX 50 MG TABLET
4110150	25	2369	$40,589.86	XELODA 500 MG TABLET
4025001	1	60	$1,268.57	VESANOID 10 MG CAPSULE
78040105	2	150	$4,268.00	GLEEVEC 100 MG TABLET
85124401	3	30	$1,087.38	TEMODAR 20 MG CAPSULE
378326694	2	80	$3,826.00	ETOPOSIDE 50 MG CAPSULE
310048230	1	30	$2,127.30	IRESSA 250 MG TABLET
3052411	9	386	$32,100.38	SPRYCEL 70 MG TABLET
50242006301	2	60	$5,935.50	TARCEVA 100 MG TABLET

78043815	21	765	$86,366.35	GLEEVEC 400 MG TABLET
50242006401	3	90	$10,234.25	TARCEVA 150 MG TABLET
69077030	2	60	$6,897.44	SUTENT 25 MG CAPSULE
85125902	2	40	$6,335.50	TEMODAR 100 MG CAPSULE
85125901	3	45	$8,019.57	TEMODAR 100 MG CAPSULE
69098030	3	84	$22,921.69	SUTENT 50 MG CAPSULE
69098038	1	28	$7,954.50	SUTENT 50 MG CAPSULE
85125201	2	10	$4,584.25	TEMODAR 250 MG CAPSULE
85125202	1	2	$938.75	TEMODAR 250 MG CAPSULE
TOTAL	972	35258	$361,164.77	

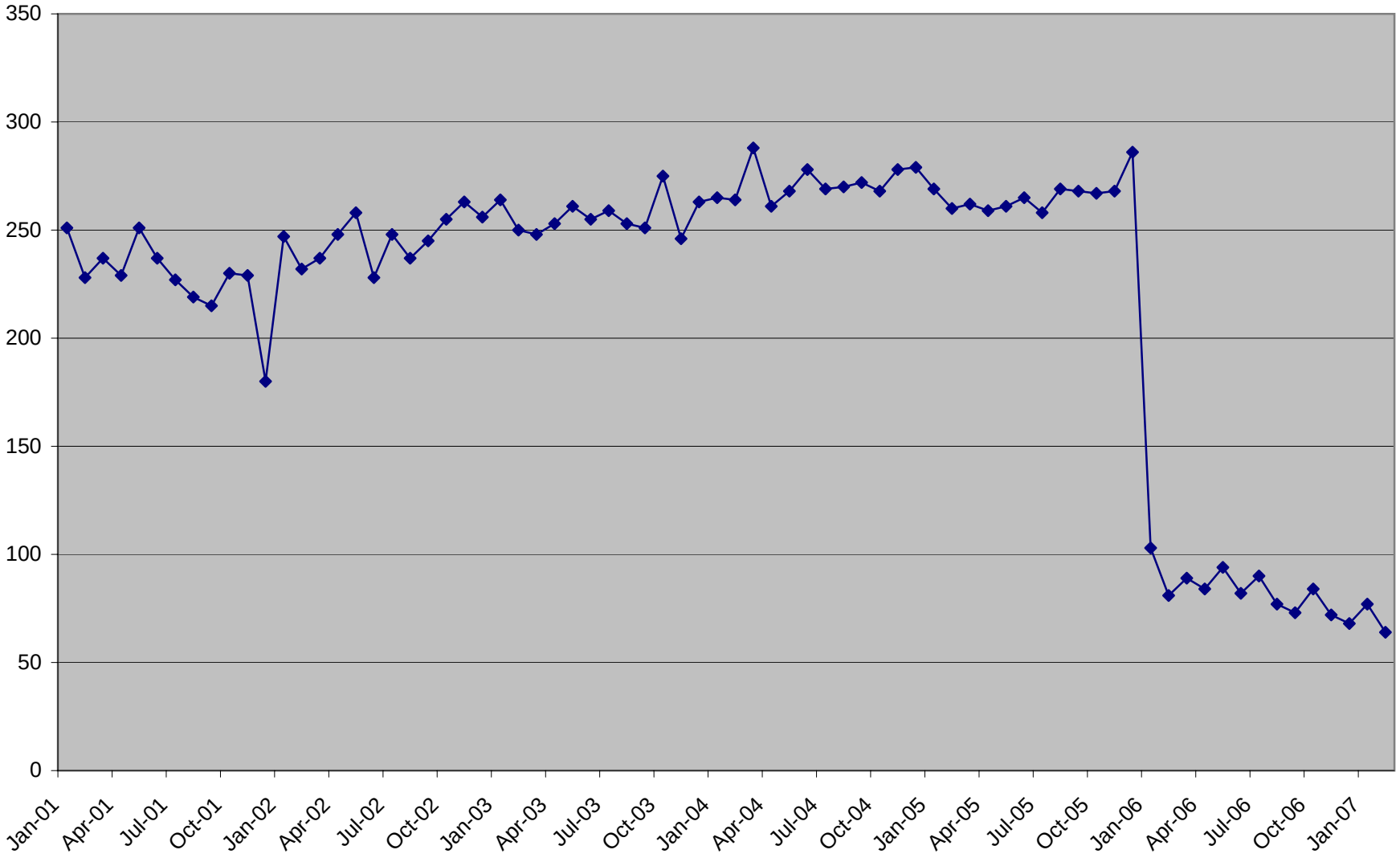
Oral Antineoplastic Utilization from 03/01/06 to 02/26/07 (cost greater than $50 per pill)

Label Name	Rx Num	Qty Dispensed	Total Claim Cost	Cost per pill
IRESSA 250 MG TABLET	1	30	$2,127.30	$70.91
SPRYCEL 70 MG TABLET	9	386	$32,100.38	$83.16
TARCEVA 100 MG TABLET	2	60	$5,935.50	$98.93
GLEEVEC 400 MG TABLET	21	765	$86,366.35	$112.90
TARCEVA 150 MG TABLET	3	90	$10,234.25	$113.71
SUTENT 25 MG CAPSULE	2	60	$6,897.44	$114.96
TEMODAR 100 MG CAPSULE	5	85	$14,355.07	$168.88
SUTENT 50 MG CAPSULE	4	112	$30,876.19	$275.68
TEMODAR 250 MG CAPSULE	3	12	$5,523.00	$460.25
Totals	50	1600	$194,415.48	17 patients

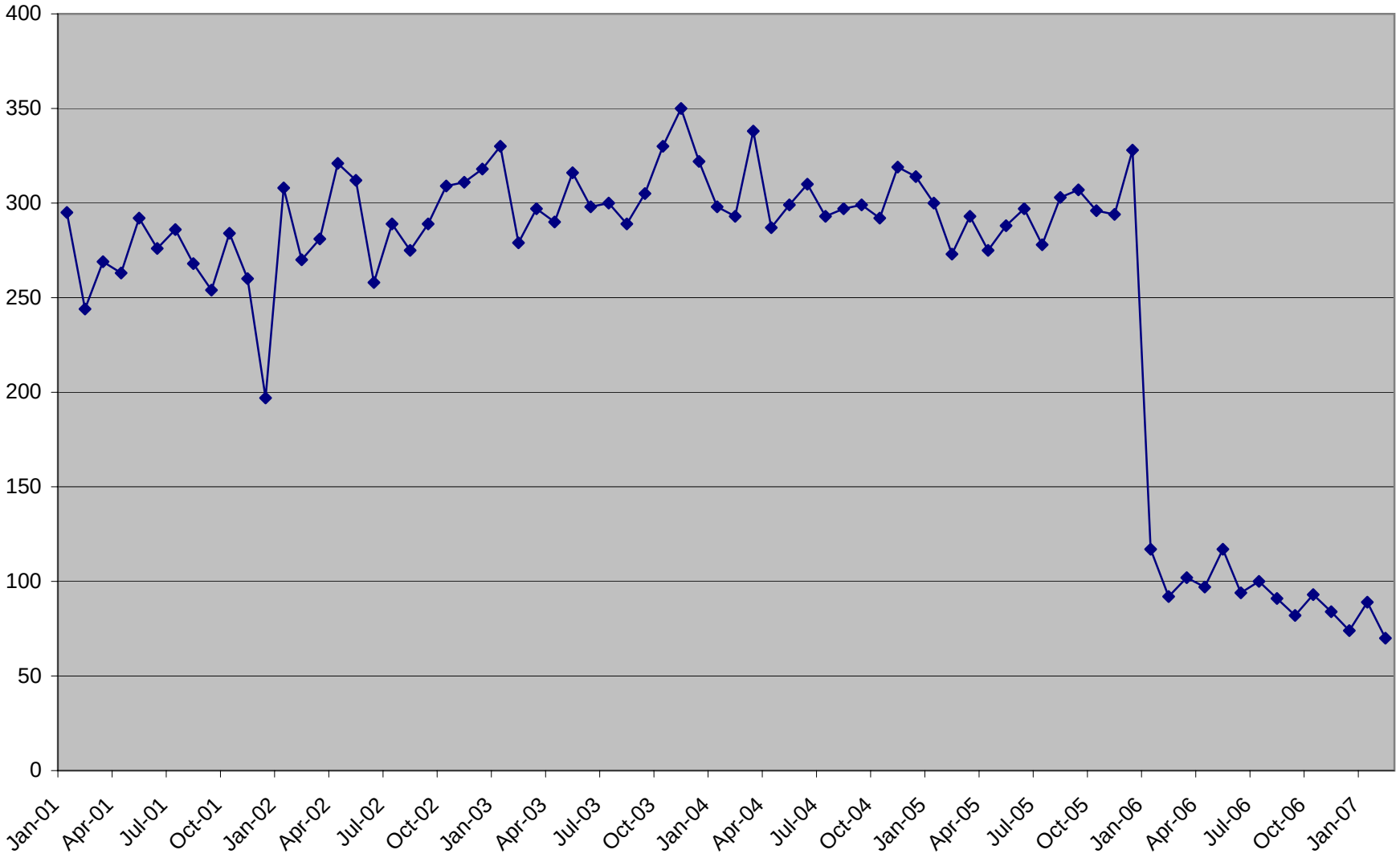
Physicians Prescribing High Cost Antineoplastics March, 2006-February, 2007

Prescribing Physician	City	Specialty	Scripts
Edward Wos	Bismarck	Oncology/Hematology	4
John Tate	Fargo	Oncology/Hematology	6
James Willardson	Grand Forks	Internal Medicine	1
Ngozi Okoro	Fargo	Oncology	3
Ferdinand Addo	Bismarck	Oncology/Hematology	2
Mahendra Gupta	Fargo	Oncology/Hematology	2
John Laurie	Grand Forks		1
Seymour Bronstein	Bismarck	Oncology/Hematology	5
Denise Snow	Fargo	Oncology/Hematology	14
Aaron Jost	Fargo		1
Walter Johnson	Fargo	Internal Medicine	2
Bipin Amin	Bismarck	Oncology/Hematology	4
Louis Geeraerts	Fargo	Oncology/Hematology	2
Elizabeth Faust	Fargo	Psychiatry	1
Howard Russell	Fargo	Oncology/Hematology	1
Out of State Provider			1

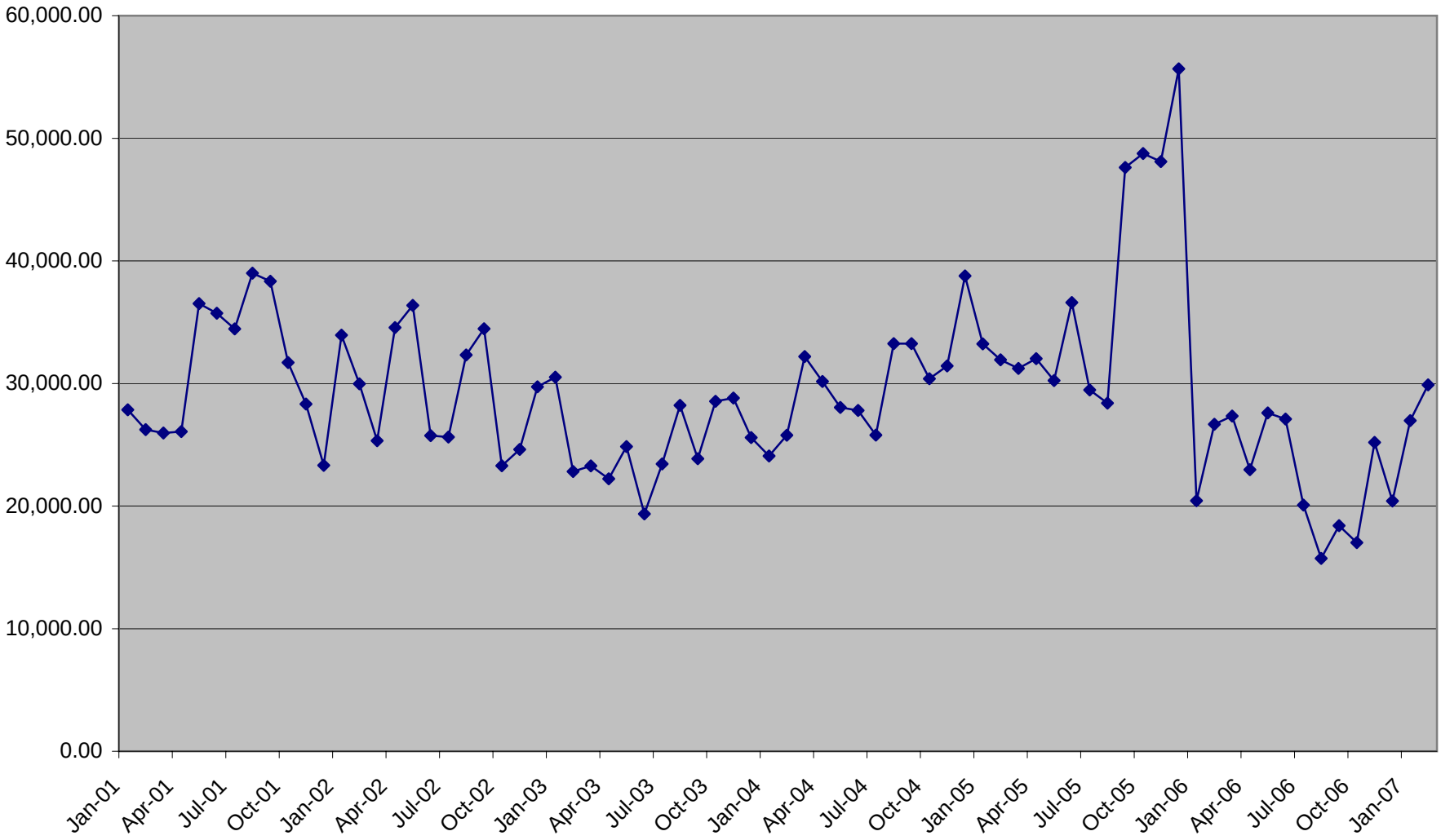
TOTAL RECIPIENTS TAKING ANTINEOPLASTICS



TOTAL RXS FOR ANTINEOPLASTICS



TOTAL CLAIMS COST FOR ANTINEOPLASTICS



HEALTH INFORMATION DESIGNS

Indications for High Cost Antineoplastics with ND utilization

Iressa[1]**-**indicated as monotherapy for the continued treatment of patients with locally advanced or metastatic non-small cell lung cancer after failure of both platinum-based and docetaxel chemotherapies who are benefiting or have benefited from Iressa.

Tarceva[2]**-**indicated as monotherapy for the treatment of patients with locally advanced or metastatic non-small cell lung cancer after failure of at least one prior chemotherapy regimen.

Sprycel[3]**-**indicated for the treatment of adults with chronic, accelerated, or myeloid or lymphoid blast phase chronic myeloid leukemia with resistance or intolerance to prior therapy including imatinib and for the treatment of adults with Philadelphia chromosome-positive acute lymphoblastic leukemia with resistance or intolerance to prior therapy.

Sutent[4]**-**indicated for the treatment of gastrointestinal stomal tumor (GIST) after disease progression on or intolerance to imatinib, and for the treatment of advanced renal cell carcinoma(RCC).

Gleevec[5]**-**indicated for the treatment of:

- Newly diagnosed adult and pediatric patients with Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase. Follow-up is limited.
- Patients with Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in blast crisis, accelerated phase, or in chronic phase after failure of interferon-alpha therapy. Gleevec is also indicated for the treatment of pediatric patients with Ph+ chronic phase CML whose disease has recurred after stem cell transplant or who are resistant to interferon-alpha therapy. There are no controlled trials in pediatric patients demonstrating a clinical benefit, such as improvement in disease-related symptoms or increased survival.
- Adult patients with relapsed or refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL).
- Adult patients with myelodysplastic/myeloproliferative diseases (MDS/MPD) associated with PDGFR (platelet-derived growth factor receptor) gene rearrangements.
- Adult patients with aggressive systemic mastocytosis (ASM) without the D816V c-Kit mutation or with c-Kit mutational status unknown.
- Adult patients with hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) who have the FIP1L1-PDGFRα fusion kinase (mutational analysis or FISH demonstration of CHIC2 allele deletion) and for patients with HES and/or CEL who are FIP1L1-PDGFRα fusion kinase negative or unknown.

- Adult patients with unresectable, recurrent and/or metastatic dermatofibrosarcoma protuberans (DFSP).
- Patients with KIT (CD117) positive unresectable and/or metastatic malignant gastrointestinal stromal tumors (GIST).

Xeloda[6]-indicated for the treatment of:

- Colon Cancer: XELODA is indicated as a single agent for adjuvant treatment in patients with Dukes' C colon cancer who have undergone complete resection of the primary tumor when treatment with fluoropyrimidine therapy alone is preferred. XELODA was non-inferior to 5-fluorouracil and leucovorin (5FU/LV) for disease-free survival (DFS). Although neither XELODA nor combination therapy prolongs overall survival (OS), combination chemotherapy has demonstrated to improve disease-free survival compared to 5-FU/LV. Physicians should consider these results when prescribing single-agent XELODA in the adjuvant treatment of Dukes' C colon cancer.
- Colorectal Cancer: XELODA is indicated as first-line treatment of patients with metastatic colorectal carcinoma when treatment with fluoropyrimidine therapy alone is preferred. Combination chemotherapy has shown a survival benefit compared to 5-FU/LV alone. A survival benefit over 5-FU/LV has not been demonstrated with XELODA monotherapy. Use of XELODA instead of 5-FU/LV in combinations has not been adequately studied to assure safety or preservation of the survival advantage.
- Breast Cancer Combination Therapy: XELODA in combination with docetaxel is indicated for the treatment of patients with metastatic breast cancer after failure of prior anthracycline-containing chemotherapy.
- Breast Cancer Monotherapy: XELODA monotherapy is also indicated for the treatment of patients with metastatic breast cancer resistant to both paclitaxel and an anthracycline-containing chemotherapy regimen or resistant to paclitaxel and for whom further anthracycline therapy is not indicated, eg, patients who have received cumulative doses of 400 mg/m2 of doxorubicin or doxorubicin equivalents. Resistance is defined as progressive disease while on treatment, with or without an initial response, or relapse within 6 months of completing treatment with an anthracycline-containing adjuvant regimen.

Indications for High Cost Antineoplastics with no current ND utilization

Zolinza[7]**-**indicated for the treatment of cutaneous manifestations in patients with cutaneous T-cell lymphoma (CTCL) who have progressive, persistent or recurrent disease on or following two systemic therapies.

Tykerb[8]**-**indicated in combination with capecitabine for the treatment of patients with advanced or metastatic breast cancer whose tumors overexpress HER2 and who have received prior therapy including an anthracycline, a taxane, and trastuzumab.

Nexavar[9]**-**indicated for the treatment of patients with advanced renal cell carcinoma.

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[1] Product information for Iressa. AstraZeneca Pharmaceuticals LP, Wilmington, DE 19850. www.iressa-us.com (accessed April 30, 2007).

[2] Product information for Tarceva. OSI Pharmaceuticals, Inc., Melville, NY 11747. www.tarceva.com (accessed April 30, 2007).

[3] Product information for Sprycel. Bristol-Myers Squibb, Princeton, New Jersey 08543. www.sprycel.com (accessed April 30, 2007).

[4] Product information for Sutent. Pfizer Labs, Divison of Pfizer, Inc., New York, NY 10017. www.sutent.com (accessed April 30, 2007).

[5] Product information for Gleevec. Novartis Pharmaceuticals, East Hanover, New Jersey 07936. www.gleevec.com (accessed April 30, 2007).

[6] Product information for Xeloda. Roche Laboratories Inc., 340 Kingsland Street, Nutley, New Jersey 07110. www.xeloda.com (accessed April 30, 2007).

[7] Product information for Zolinza. Merck & CO., Inc., Whitehouse Station, New Jersey 08889. www.zolinza.com (accessed April 30, 2007).

[8] Product information for Tykerb. GlaxoSmithKline, Research Triangle Park, NC 27709. www.tykerb.com (accessed April 30, 2007).

[9] Product information for Nexavar. Onyx Pharmaceuticals, Inc., 2100 Powell Street, Emeryville, CA 94608. www.nexavar.com (accessed April 30, 2007).

BlueCross BlueShield of North Dakota
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Corporate Medical Policy

Gleevec

Effective Date: Update to current policy

Description

The FDA has approved Gleevec ™ (imatinib mesylate) for the treatment of gastrointestinal stromal tumors (GIST). GISTs are the most common malignant form of sarcoma in the gastrointestinal tract.

Previously, the FDA had approved Gleevec ™ (imatinib mesylate) for the treatment of patients with chronic myeloid leukemia (CML) in blast crisis, accelerated phase, or in chronic phase after failure of interferon-alpha therapy.

Policy/Criteria

Prior approval is required with the exception of Federal Employees Program (FEP).

Patients enrolled in a formal, clinical study for other indications for Gleevec may also be eligible for benefits upon review of a written prior approval request.

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.

Source

Prescribing information for Gleevec. December 2002.
http://www.pharma.us.novartis.com/product/pi/pdf/Gleevec.pdf

BlueCross BlueShield of North Dakota
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Corporate Medical Policy

Iressa (gefitinib)

Effective Date: June 3, 2003

Description

Iressa (gefitinib) is an oral agent approved by the FDA as a single agent treatment for patients with advanced non-small cell lung cancer (NSCLC) whose cancer has continued to progress despite treatment with platinum-based and docetaxel chemotherapy. NSCLC is the most common type of lung cancer, accounting for almost 80% of lung cancers.

Approval was granted under FDA's accelerated approval program which is intended to allow patients suffering from serious or life-threatening diseases earlier access to promising new drugs. As required by this approval, additional studies will be conducted to verify the drug's clinical benefit.

Policy/Criteria

Prior approval is required except for Federal Employees Program (FEP) members.

Benefits for Iressa will be allowed as monotherapy for the treatment of patients with locally advanced or metastatic non-small cell lung cancer after failure of both platinum-based and docetaxel chemotherapies.

Iressa is not indicated as initial treatment with standard, platinum-based chemotherapy. Results from two large, controlled, randomized trials in initial treatment of NSCLC showed no benefit from adding Iressa.

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.

Source

1. 1. FDA News. May 5, 2003. FDA Approves New Type of Drug for Lung Cancer. http://www.fda.gov/bbs/topics/NEWS/2003/NEW00901.html (Last Accessed 6/12/2003)
2. 2. Iressa product labeling. AstraZeneca Pharmaceuticals LP

BlueCross BlueShield of North Dakota
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Corporate Medical Policy

Nexavar® (sorafenib)

Effective Date: January 15, 2006

Description

Nexavar® is an oral tablet FDA approved for the treatment of patients with advanced renal cell carcinoma (RCC).

In the United States, RCC or kidney cancer accounts for approximately 3 percent of all adult cancers. According to the American Cancer Society, about 32,000 new cases are diagnosed and about 12,000 die from the disease annually. If detected early enough, kidney cancer may be curable surgically.

Nexavar® targets tumor cell proliferation (tumor growth) and tumor angiogenesis (tumor blood supply).

Nexavar® is currently in Phase III clinical trials for the treatment of advanced hepatocellular carcinoma and metastatic melanoma. A trial is also planned for non-small cell lung cancer.

Policy/Criteria

Prior approval is required except for Federal Employees Program (FEP).

Benefits will be allowed for Nexavar® for the treatment of patients with advanced renal cell carcinoma.

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.

Source

Nexavar® product labeling

FDA News. FDA Approves New Treatment for Advanced Kidney Cancer. December 20, 2005

Medical News Today. New Advanced Renal Cell Carcinoma Drug, Nexavar Granted U.S. Approval. Dec 27, 2005. http://www.medicalnewstoday.com/medicalnews.php?newsid=35421. Last accessed 1/12/2006.

BlueCross BlueShield of North Dakota
An independent licensee of the Blue Cross & Blue Shield Association

Corporate Medical Policy

Sprycel™ (dasatinib malate)

Effective Date: July 15, 2006

Description

Sprycel™ is an oral agent approved by the FDA for patients with chronic, accelerated, or myeloid or lymphoid blast phase chronic myeloid leukemia with resistance or intolerance to prior therapy, including imatinib (Gleevec). The effectiveness of Sprycel™ is based on hematologic and cytogenetic response rates. There are no controlled trials demonstrating a clinical benefit, such as improvement in disease-related symptoms or increased survival.

Sprycel™ is also indicated for the treatment of adults with Philadelphia-chromosome positive acute lymphoblastic leukemia with resistance or intolerance to prior therapy.

Chronic myeloid leukemia (CML) is a cancer of blood cells, characterized by replacement of the bone marrow with malignant, leukemic cells. Many of these leukemic cells can be found circulating in the blood and cause enlargement of the spleen, liver, and other organs. CML is usually diagnosed by finding a specific chromosomal abnormality called the Philadelphia (Ph) chromosome, named after the city where it was first recorded.

Policy/Criteria

Prior approval is required with the exception of Federal Employees Program (FEP).

Benefits for Sprycel™ will be allowed for patients with chronic myeloid leukemia after disease progression on, or intolerance to, imatinib mesylate (Gleevec). Benefits for Sprycel™ will also be allowed for the treatment of adults with Philadelphia-chromosome positive acute lymphoblastic leukemia with resistance or intolerance to prior therapy.

Patients enrolled in a formal, clinical study for other indications for Sprycel™ may also be eligible for benefits upon review of a written prior approval request.

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.

Source

Prescribing information for Sprycel. June 2006.
http://www.fda.gov/cder/foi/label/2006/021986lbl.pdf

FDA news. FDA Gives Rapid Approval for a New Treatment For a Rare Type of Leukemia.
http://www.fda.gov/bbs/topics/NEWS/2006/NEW01400.html

BlueCross BlueShield of North Dakota
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Corporate Medical Policy

Sutent™ (sunitinib malate)

Effective Date: March 20, 2006

Description

Sutent™ is an oral agent approved by the FDA for patients with gastrointestinal stromal tumors (GIST) whose disease has progressed or who are unable to tolerate treatment with imatinib mesylate (Gleevec™), another oral treatment approved for GIST patients. GIST is a rare type of cancer that originates in the wall of the gastrointestinal track. The American Cancer Society estimates that only approximately 5,000 individuals are diagnosed annually with GIST in the U.S.

The FDA also granted accelerated approval for Sutent for the treatment of patients with advanced renal cell carcinoma (RCC). Approval was granted under FDA's accelerated approval program which is intended to allow patients suffering from serious or life-threatening diseases earlier access to promising new drugs. There are no randomized trials of Sutent™ demonstrating clinical benefit such as increased survival or improvement in disease-related symptoms in renal cell carcinoma. As required by this approval, additional studies will be conducted to verify the drug's clinical benefit.

Sutent™ is a protein tyrosine kinase inhibitor working through multiple targets to deprive the tumor cells of the blood and nutrients needed to grow. Protein tyrosine kinases are enzymes that provide a central switch mechanism in cellular signal transduction pathways. These enzymes are involved in many cellular processes such as cell proliferation, metabolism, survival and apoptosis. Several protein tyrosine kinases are known to be activated in cancer cells and to drive tumor growth and progression. Sutent™ inhibits signaling through multiple tyrosine receptor kinases, including platelet-derived growth factor receptor and vascular endothelial growth factor receptor.

Policy/Criteria

Prior approval is required with the exception of Federal Employees Program (FEP).

Benefits for Sutent™ will be allowed for gastrointestinal stromal tumors (GIST) after disease progression on, or intolerance to, imatinib mesylate (Gleevec). Benefits for Sutent™ will also be allowed for patients with advanced renal cell carcinoma (RCC).

Patients enrolled in a formal, clinical study for other indications for Sutent™ may also be eligible for benefits upon review of a written prior approval request.

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.

Source

Prescribing information for Sutent. January 2006.
http://www.fda.gov/cder/foi/label/2006/021968lbl.pdf FDA news. FDA Approves New Treatment for Gastrointestinal and Kidney Cancer. January 26, 2006.
http://www.fda.gov/bbs/topics/news/2006/NEW01302.html

BlueCross BlueShield of North Dakota
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Corporate Medical Policy

Erlotinib (Tarceva)

Updated**:** August 2006

Effective Date: January 1, 2005

Description

Erlotinib is a small molecule designed to target the human epidermal growth factor receptor 1 (HER1) pathway, which is one of the factors critical to cell growth in Non-Small Cell Lung (NSCLC) and pancreatic cancer. HER1, also known as Epidermal Growth Factor Receptor (EGFR), is a component of the HER signaling pathway, which plays a role in the formation and growth of numerous cancers. Erlotinib is designed to inhibit the tyrosine kinase activity of the HER1 signaling pathway inside the cell, which may block tumor cell growth.

Policy/Criteria

Prior approval is required except for FEP members.

- o Erlotinib is an oral agent indicated for the treatment of patients with locally advanced or metastatic Non-Small Cell Lung Cancer (NSCLC) after failure of at least one prior chemotherapy regimen.

  Results from two Phase III trials in first-line patients with locally advanced or metastatic NSCLC showed no clinical benefit with the concurrent administration of erlotinib with platinum-based chemotherapy (carboplatin and paclitaxel or gemcitabine and cisplatin). Therefore, its use first-line as concurrent therapy is not covered.

- o Erlotinib in combination with gemcitabine is indicated for the first-line treatment patients with locally advanced, unresectable or metastatic pancreatic cancer.

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.

Source

Tarceva (erlotinib). Prescribing information. Genentech. http://www.tarceva.com/tarceva/product/indexPrint.jsp (Last accessed 8/11/2006).

UNICARE.

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Sprycel® (dasatanib)

Complete form in its entirety and fax to:

Prior Authorization of Benefits (PAB) Center at (877) 809- 3201

1. PATIENT INFORMATION

Patient Name: _____

Patient ID #: _____

Patient DOB: _____

Date of Rx: _____

2. PHYSICIAN INFORMATION

Prescribing Physician: _____

Physician Address: _____

Physician Phone #: _____

Physician Fax #: _____

Physician Specialty: _____

Physician DEA: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
□ Sprycel (dasatanib)	□ 20mg □ 50mg □ 70mg	_____	Specify: _____

7. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

□ Yes	□ No	Is the patient 18 years of age or older? **AND**
□ Yes	□ No	Has the patient been diagnosed with Chronic Myeloid Leukemia (CML)? **OR**
□ Yes	□ No	Has the patient been diagnosed with Philadelphia chromosome-positive Acute Lymphoblastic Leukemia (ALL)? **AND**
□ Yes	□ No	Has the disease progressed or developed intolerance while using other chemotherapy (i.e., Gleevec)?

Medical Necessity (please attach all supporting documentation**):**

_____

_____

_____

_____

8. PHYSICIAN SIGNATURE

_____ _____

Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

UNICARE.

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Nexavar® (sorafenib)

Complete form in its entirety and fax to:

Prior Authorization of Benefits (PAB) Center at (877) 809- 3201

1. PATIENT INFORMATION

Patient Name: _____

Patient ID #: _____

Patient DOB: _____

Date of Rx: _____

2. PHYSICIAN INFORMATION

Prescribing Physician: _____

Physician Address: _____

Physician Phone #: _____

Physician Fax #: _____

Physician Specialty: _____

Physician DEA: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
□ Nexavar (sorafenib)	□ 200mg	_____	Specify: _____

7. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

□ Yes □ No Has the patient been diagnosed with Renal Cell Carcinoma? **OR**

□ Yes □ No Has the patient been diagnosed with Kidney Cancer?

Medical Necessity (please attach all supporting documentation**):**

_____

_____

_____

_____

8. PHYSICIAN SIGNATURE

_____ _____

Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

UNICARE.

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Gleevec® (imatinib)

Complete form in its entirety and fax to:

Prior Authorization of Benefits (PAB) Center at (877) 809- 3201

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
	Physician Specialty: _____
	Physician DEA: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
□ Gleevec (imatinib)	□ 100mg □ 400mg	_____	Specify: _____

7. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

□ Yes □ No Has the patient been diagnosed with Philadelphia chromosome positive (Ph+) chronic myeloid leukemia (CML)? **OR**

□ Yes □ No Has the patient been diagnosed with Gastrointestinal Stromal Tumors (GIST)?

Medical Necessity (please attach all supporting documentation**):**

_____

_____

_____

_____

8. PHYSICIAN SIGNATURE

_____ _____

Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

UNICARE.

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Xeloda® (capecitabine)

Complete form in its entirety and fax to:

Prior Authorization of Benefits (PAB) Center at (877) 809- 3201

1. PATIENT INFORMATION

Patient Name: _____

Patient ID #: _____

Patient DOB: _____

Date of Rx: _____

2. PHYSICIAN INFORMATION

Prescribing Physician: _____

Physician Address: _____

Physician Phone #: _____

Physician Fax #: _____

Physician Specialty: _____

Physician DEA: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
□ Xeloda (capecitabine)	□ 150mg □ 500mg	_____	Specify: _____

7. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

□ Yes	□ No	Has the patient been diagnosed with Dukes' C Colon Cancer? **OR**
□ Yes	□ No	Has the patient been diagnosed with Metastatic Colorectal Carcinoma? **OR**
□ Yes	□ No	Has the patient been diagnosed with Metastatic Breast Cancer? **AND**
□ Yes	□ No	Will the patient be using Xeloda in combination with Taxotere (docetaxol)? **AND**
□ Yes	□ No	Has the disease progressed or developed intolerance to other chemotherapy regimens? **OR**
□ Yes	□ No	Is the patient using monotherapy? **AND**
□ Yes	□ No	Has the disease progressed or developed intolerance to both Taxol (paclitaxel) and other chemotherapy regimens?

Medical Necessity (please attach all supporting documentation**):**

_____

_____

_____

_____

8. PHYSICIAN SIGNATURE

_____ _____

Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

UNICARE.

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Tarceva® (erlotinib)

Complete form in its entirety and fax to:

Prior Authorization of Benefits (PAB) Center at (877) 809- 3201

1. PATIENT INFORMATION

Patient Name: _____

Patient ID #: _____

Patient DOB: _____

Date of Rx: _____

2. PHYSICIAN INFORMATION

Prescribing Physician: _____

Physician Address: _____

Physician Phone #: _____

Physician Fax #: _____

Physician Specialty: _____

Physician DEA: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
□ Tarceva (erlotinib)	□ 25mg □ 100mg □ 150mg	_____	Specify: _____

7. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

□ Yes □ No Has the patient been diagnosed with Metastatic Non-Small Cell Lung Cancer (NSCLC)? **AND**

□ Yes □ No Has the disease progressed despite treatment with another antineoplastic agent (i.e., cisplatin, carboplatin, paclitaxel, or gemcitabine)? **OR**

□ Yes □ No Has the patient been diagnosed with pancreatic cancer? **AND**

□ Yes □ No Will the patient be using Tarceva in combination with Gemzar (gemcitabine)?

Medical Necessity (please attach all supporting documentation**):**

_____

_____

_____

_____

8. PHYSICIAN SIGNATURE

_____ _____

Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

UNICARE.

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Sutent® (sunitinib)

Complete form in its entirety and fax to:

Prior Authorization of Benefits (PAB) Center at (877) 809- 3201

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
	Physician Specialty: _____
	Physician DEA: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
□ Sutent (sunitinib)	□ 12.5mg □ 25mg □ 50mg	_____	Specify: _____

7. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

□ Yes □ No	Has the patient been diagnosed with Gastrointestinal Stromal Tumor (GIST)? **AND**
□ Yes □ No	Has the disease progressed or developed intolerance with the patient on Gleevec? **OR**
□ Yes □ No	Has the patient been diagnosed with Renal Cell Carcinoma (RCC)? **OR**
□ Yes □ No	Has the patient been diagnosed with Kidney Cancer?

Medical Necessity (please attach all supporting documentation**):**

_____

_____

_____

_____

8. PHYSICIAN SIGNATURE

_____ _____

Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.