ATRIO HEALTH PLANS

Bladder Cancer
Adstiladrin (Nadofaragene Firadenovec-vncg) J9029
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)**

- ☐ The member has non-muscle invasive bladder cancer; and
- ☐ The disease is high-risk; and
- ☐ The disease is Bacillus Calmette-Guerin (BCG)-unresponsive.

If not, please provide **clinical rationale** for formulary exception: _____
_____

☐ Continuation Requests: (Clinical documentation required for all requests)

- ☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**
- ☐ 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 DOES NOT GUARANTEE PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Bladder Cancer PA

Drug Name(s):

ADSTILADRIN **NADOFARAGENE FIRADENOVEC-VNCG**

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Drug meets utilization management criteria:
3. 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:

- **N/A**

Prescriber Restrictions:

- **N/A**

Coverage Duration:

Initial Approval will be for 6 months. Continuation will be approved upto 12 months.

FDA Indications:

- Treatment of adult patients with high-risk Bacillus Calmette-Guerin (BCG)-unresponsive non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors

Off-Label Uses:

- N/A

Age Restrictions:

- Safety and effectiveness have not been established in pediatric patients

Other Clinical Consideration:

- N/A

Resouces:

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