UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Piqray (alpelisib)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met):

1. Is the patient 18 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of hormone receptor(HR)-positive, human epidermal growth factor receptor 2 (HER-2) negative, PIK3CA-mutated, advanced, or metastatic breast cancer as detected by an FDA-approved test? ❑ **Yes** ❑ **No**
3. Is the medication being prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**
4. Has the patient tried and failed aromatase inhibitor-based treatment as recommended by the NCCN guidelines? ❑ **Yes** ❑ **No**
5. Will Piqray be used in conjunction with fulvestrant as recommended by the NCCN guidelines? ❑ **Yes** ❑ **No**
6. Does the provider attest to counseling the patient on the severe adverse effects and appropriate management (severe cutaneous adverse reaction (SCAR), hyperglycemia, pneumonitis, diarrhea or colitis, pancreatitis)? ❑ **Yes** ❑ **No**

Reauthorization Criteria (*All* of the following criteria must be met)**:**

1. Has the patient **NOT** experienced any disease progression? ❑ **Yes** ❑ **No**
2. Has the patient **NOT** experienced unacceptable toxicity? ❑ **Yes** ❑ **No**

Initial Authorization: Up to six (6) months
Reauthorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date