

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049



Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Trisenox® (Arsenic Trioxide): Prior Authorization Request Form: Please respond.

- Please complete the attached Trisenox® (Arsenic Trioxide) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Trisenox® (Arsenic Trioxide)

The following adverse effects characterized by fever, dyspnea, weight gain, pulmonary infiltrates and pleural or pericardial effusions, with or without leukocytosis may be indicative of a fatal syndrome, Acute promyelocytic leukemia (APL) Differentiation Syndrome (also known as retinoic-acid-Acute Promyelocytic leukemia (RA-APL). High dose steroids (dexamethasone 10 mg intravenously twice daily) should be immediately initiated, irrespective of the leukocyte count, and continued for at least 3 days or longer until the signs and symptoms have abated.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

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M0018_PATEMP_1107 CMS 11/28/07 H5656

Prior Authorization Request Form



Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Trisenox® (Arsenic Trioxide) Criteria

- 1 Please indicate Trisenox®'s dispensing location:
 pharmacy
 physician's supply incident to a physician's service
 other: _____
 - 2 Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed
 Acute promyelocytic leukemia (APL) (ICD-9: 205.0), FAB M3 in patients who are refractory to or have relapsed from retinoid and anthracycline chemotherapy?
 Myelodysplastic syndromes (ICD-9: 238.72-238.75)(monotherapy in transfusion dependent patients)
 Other (diagnosis and ICD-9 code): _____
 - 3 Is the prescribing physician a hematologist/ oncologist or has one been consulted?
 Yes No
 - 4 Will Trisenox® be administered in a facility where the patient can be closely monitored for an appropriate period based on health status?
 Yes No
 - 5 Does the patient have any contraindications to the use of Trisenox®(e.g., hypersensitivity)?
 Yes No
 - 6 Is the patient currently receiving any of the following contraindicated medications that increase the QT interval: bepridil, fosfarnet, mesoridazine, pimozide, ranolazine, thioridazine, or ziprasidone?
 Yes No
- Routine monitoring of serum electrolytes (e.g, calcium, potassium and magnesium) and ECG is required during arsenic administration. Arsenic trioxide should be cautiously with concomitant administration of QT prolonging drugs and potassium-wasting diuretics

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____