

Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Alectinib HCI (Alecensa) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Alectinib HCI (Alecensa)**. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: <u>1-866-331-2104</u>]. If you have any questions or concerns, please call <u>1-866-331-2103</u>. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** http://pithelp.appl.kp.org/MAS/formulary.html

	1 – Patient Information		
Patient Name:	Kaiser Medical ID#:	Date of Birth:	
	2 – Provider Information		
Prescriber specialty: ☐ Hematologist ☐ C	Oncologist 🗆 other:		
If consulted with a specialist, specialist name and specialty:			
Provider Name:	Provider NPI:		
Provider Address:			
Provider Phone #:	Provider Fax #:		
Please check the boxes that apply: □Initial Request □ Continuation of Ther	apy Request		
3 – Pharmacy Information			
Pharmacy Name:	Pharmacy NPI:		
Pharmacy Phone #	Pharmacy Fax #:		
	4 – Drug Therapy Requested		
Drug 1: Name/Strength/Formulation:			
Drug 2: Name/Strength/Formulation:			

5 – Diagnosis			
Indications:			
□ Metastatic Non-Small Cell Lung Cancer (mNSCLC)			
□ Other:			
6-Clinical Criteria			
Initial Therapy:			
1. Does the member have both of the following?			
a) □ No □ Yes Diagnosis of metastatic non-small cell lung cancer (mNSCLC)			
b) □ No □ Yes Anaplastic lymphoma kinase (ALK) translocation-positive mutation			
Continuation of Therapy:			
Member does NOT show evidence of progressive disease while on therapy: □ No □ Yes			
7 – Provider Sign-Off			
Additional information. Disease exercide our additional information that about the taken into assertion			

7 – Provider Sign-Off Additional Information – Please provide any additional information that should be taken into consideration.			
Additional Information – Please provide any additional Inform	ation that should be taken into consideration.		
I certify that the information provided is accurate. Supporting doc	cumentation is available for State audits.		
Provider Signature:	Date:		
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