Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
ALPELISIB (VIJOICE)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for alpelisib (Vijoice). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1) **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2) **Patient has a diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS) confirmed by genetic testing demonstrating a PIK3CA mutation; and**
3) **Patient's condition is severe or life-threatening requiring systemic therapy as determined by treating prescriber; and**
4) **Patient has at least one target lesion identified on imaging.**

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Request for continuation of therapy will be considered with documentation of a positive response to therapy as evidenced by a reduction in sum of measurable lesion volume across 1 to 3 target lesions.

Non-Preferred

☐ Vijoice

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis (Attach copy of genetic testing): _____

Is patient's condition severe or life-threatening requiring systemic therapy as determined by treating prescriber?

☐ No ☐ Yes

Does patient have at least one target lesion identified on imaging? ☐ No ☐ Yes

Renewal Requests:

Document positive response to therapy as evidenced by a reduction in sum of measurable lesion volume across 1 to 3 target lesions: _____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*