

Instructions for Professional Services Providers submitting request for Prior Authorization for Brentuximab Vedotin (J9042)

Effective April 18, 2013 , Louisiana Medicaid will require prior authorization for the chemotherapy drug J9042: Brentuximab Vedotin. Brentuximab Vedotin is a chemotherapy drug used in the treatment of:

- Hodgkin's Lymphoma
 - After failure of an autologous stem cell transplant or
 - Failure of at least two multidrug chemotherapy regimens

Or

- Systemic anaplastic large-cell lymphoma
 - After failure of at least one prior multidrug chemotherapy regimen

Provider should submit the following information when requesting Prior Authorization for J9042 (Brentuximab Vedotin):

- Completed PA-01 Form (Type 99)
 - Begin and End dates should reflect the period of time for three to four cycles of the injection
 - Requested Units will depend on the current weight of the patient
- Physician Prescription
- Documentation to justify the use of the chemotherapy drug will be needed with the original request
- (With subsequent request, submit justification for the continuation of the Chemotherapy Drug)

Providers can also submit the request via Electronic Prior Authorization Process (ePA).

If you have any questions, please contact DXC Prior Authorization Department at (800) 488-6334 or (225)928-5263

Instructions For Completing Prior Authorization Form (PA-01)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PRIOR AUTHORIZATION DEPARTMENT AT UNISYS.

- FIELD NO. 1** CHECK THE APPROPRIATE BLOCK TO INDICATE THE TYPE OF PRIOR AUTHORIZATION REQUESTED.
- FIELD NO. 2** ENTER RECIPIENT'S 13-DIGIT MEDICAID ID NUMBER OR THE 16-DIGIT CCN NUMBER.
- FIELD NO. 3** ENTER THE RECIPIENT'S SOCIAL SECURITY NUMBER.
- FIELD NO. 4** ENTER THE RECIPIENT'S LAST NAME, FIRST NAME AND MIDDLE INITIAL AS IT APPEARS ON THEIR MEDICAID CARD.
- FIELD NO. 5** ENTER THE RECIPIENT'S DATE OF BIRTH IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).
- FIELD NO. 6** ENTER THE PROVIDER'S 7-DIGIT MEDICAID NUMBER. IF ASSOCIATED WITH A GROUP, ENTER THE ATTENDING PROVIDER NUMBER ONLY.
- FIELD NO. 7** ENTER THE BEGINNING AND ENDING DATES OF SERVICE IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR). REQUESTED DATES SHOULD REFLECT THE PERIOD OF TIME FOR THREE TO FOUR CYCLES OF THE INJECTION.
- FIELD NO. 8** ENTER THE NUMERIC ICD9-DIAGNOSIS CODE (PRIMARY & SECONDARY) AND THE CORRESPONDING DESCRIPTION.
- FIELD NO. 9** ENTER THE DAY THE PRESCRIPTION, DOCTOR'S ORDERS WAS WRITTEN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR).
- FIELD NO. 10** ENTER THE NAME OF THE RECIPIENT'S ATTENDING PHYSICIAN PRESCRIBING THE SERVICES.
- FIELD NO. 11** ENTER THE HCPCS / PROCEDURE CODE.
- FIELD NO. 11A** ENTER THE CORRESPONDING MODIFIERS (WHEN APPROPRIATE).
- FIELD NO. 11B** ENTER THE CORRESPONDING DESCRIPTION FOR EACH PROCEDURE REQUESTED.
- FIELD NO. 11C** ENTER THE NUMBER OF UNITS REQUESTED (CALCULATED UNITS WILL DEPEND ON THE CURRENT WEIGHT OF THE PATIENT)
- FIELD NO. 11D** ENTER THE REQUESTED CHARGES FOR EACH INDIVIDUAL HCPC/ PROCEDURE WHEN APPROPRIATE FOR THE REQUESTED HCPC/ PROCEDURE.
- FIELD NO. 12** ENTER THE LOCATION FOR ALL SERVICES RENDERED.
- FIELD NO. 13** ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE PROVIDER OF SERVICE.
- FIELD NO. 14** ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE RECIPIENT'S CASE MANAGER , IF AVAILABLE
- FIELD NO. 15** PROVIDER/AUTHORIZED SIGNATURE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF NOT SIGNED. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL.
- FIELD NO. 16** DATE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF FIELD IS NOT DATED.

IF YOU HAVE ANY QUESTIONS CONCERNING THE PRIOR AUTHORIZATION PROCESS, PLEASE CONTACT THE PRIOR AUTHORIZATION DEPARTMENT AT UNISYS:

PRIOR AUTHORIZATION TOLL-FREE NO. IS 1-800-488-6334

PRIOR AUTHORIZATION UNIT NO IS 1- 225-928-5263

PRIOR AUTHORIZATION FAX NO. IS 1-225-216-6481