

Danyelza[®] (Naxitamab-gqqg) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Physician billing (HPCS code: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

Billing Provider Information

Provider NPI: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

For Initial Authorization:

Neuroblastoma

1. Is diagnosis relapsed or refractory high-risk neuroblastoma? Yes ___ No ___
2. Is disease in the bone or bone marrow demonstrating a partial response, minor response, or stable disease to prior therapy (i.e., no progressive disease following most recent therapy)? Yes ___ No ___
3. Will naxitamab-gqqg be used in combination with a granulocyte-macrophage colony-stimulating factor (GM-CSF) according to package labeling (GM-CSF dosed at 250mcg/m²/day daily starting 5 days prior to Danyelza[®] therapy and 500mcg/m²/day daily on days 1 to 5 of Danyelza[®] therapy)? Yes ___ No ___
4. Does prescriber agree to provide the member appropriate premedication for pain management and neuropathic pain (e.g., oral opioids, gabapentin)? Yes ___ No ___
5. Does prescriber agree to provide the member appropriate premedication for infusion-related reactions and nausea/vomiting including an intravenous (IV) corticosteroid, a histamine 1 (H₁) antagonist, an H₂ antagonist, acetaminophen, and an antiemetic? Yes ___ No ___

If answer is none of the above, please indicate diagnosis: _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on naxitamab-gqqg? Yes ___ No ___
3. Has the member experienced adverse drug reactions related to naxitamab-gqqg? Yes ___ No ___
If yes, please specify adverse reactions: _____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds[®] or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**

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