Jelmyto
Jelmyto (mitomycin) J9281
Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ **New Start or Initial Request: (Clinical documentation required for all requests)**

☐ Patient has a diagnosis of low-grade Upper Tract Urothelial Cancer; AND

☐ Cancer is non-metastatic; AND

☐ Patient has at least one visible tumor with a diameter of at least 5 mm but no more than 15 mm located above the ureteropelvic junction.

- Requests for Jelmyto (mitomycin gel) may not be approved for patients with perforation of the bladder or upper urinary tract;

☐ **Continuation Requests: (Clinical documentation required for all requests)**

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Jelmyto Drug PA

Drug Name(s):

JELMYTO **MITOMYCIN**

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

Oncologist, Urologist or another related specialist

Coverage Duration:

Initial Approval will be for 6 months
Continuation will be approved for 12 months

FDA Indications:

Jelmyto

- Gastric cancer, Disseminated adenocarcinoma, in combination with other agents
- Operation for glaucoma, Ab externo; Adjunct
- Pancreatic cancer, Disseminated adenocarcinoma, in combination with other agents
- Transitional cell carcinoma of upper urinary tract, Low-grade

Off-Label Uses:

Jelmyto

- Biliary tract cancer, Advanced
- Breast cancer
- Carcinoma of bladder
- Cervical cancer
- Colorectal cancer
- Head and neck cancer
- Malignant mesothelioma
- Malignant neoplasm of liver
- Non-small cell lung cancer
- Primary malignant neoplasm of anus
- Rectal cancer
- Sarcoma

Age Restrictions:

N/A

Other Clinical Consideration:

- History of hypersensitivity or idiosyncratic reaction to mitomycin
- Thrombocytopenia, coagulation disorder, or an increase in bleeding tendency due to other causes
- Perforation of the bladder or upper urinary tract (pyelocalyceal solution)

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/493C21/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/7724C6/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=379200&contentSetId=100&title=Mitomycin&servicesTitle=Mitomycin&brandName=Jelmyto&UserMdxSearchTerm=Jelmyto&=null#