Halaven® Prior Authorization Request Form

Member Information (required)  Provider Information (required)

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance ID#:</td>
<td>NPI#:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Office Phone:</td>
</tr>
<tr>
<td>Street Address:</td>
<td>Office Fax:</td>
</tr>
<tr>
<td>City: State: Zip:</td>
<td>Office Street Address:</td>
</tr>
<tr>
<td>Phone:</td>
<td>City: State: Zip:</td>
</tr>
</tbody>
</table>

Medication Information (required)

<table>
<thead>
<tr>
<th>Medication Name:</th>
<th>Strength:</th>
<th>Dosage Form:</th>
</tr>
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<tbody>
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- Check if requesting **brand**
- Check if request is for **continuation of therapy**

Clinical Information (required)

Select the diagnosis below:
- Breast cancer
- Liposarcoma
- Other diagnosis: ___________________________ ICD-10 Code(s): ___________________________

Clinical Information:
- Is this request for continuation of prior Halaven therapy?  Yes  No
- Has the patient used Halaven in the past 120 days?  Yes  No
- Is Halaven prescribed by or in consultation with an oncologist?  Yes  No

For breast cancer, also answer the following:
- Does the patient have recurrent or metastatic disease?  Yes  No
- Has the patient had previous treatment with an anthracycline [e.g., doxorubicin, Ellence (epirubicin)]?  Yes  No
- Has the patient had previous treatment with a taxane [e.g., paclitaxel, Taxotere (docetaxel)]?  Yes  No

For liposarcoma, also answer the following:
- Does the patient have unresectable or metastatic disease?  Yes  No
- Has the patient had previous treatment with one anthracycline-containing regimen?  Yes  No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

________________________________________________________________________________

________________________________________________________________________________

Please note: This request may be denied unless all required information is received. If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.