MASSACHUSETTS

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Elzonris (tagraxofusp-erzs) for the Treatment of Blastic Plasmacytoid Dendritic Cell Neoplasm (BPDCN) Prior Authorization Request Form #928

Medical Policy #009 Elzonris (tagraxofusp-erzs) for the Treatment of Blastic Plasmacytoid Dendritic Cell Neoplasm (BPDCN)

Please use this form to assist in identifying members who meet Blue Cross Blue Shield of Massachusetts' (BCBSMA's) medical necessity criteria for Elzonris (tagraxofusp-erzs). For members who do not meet the criteria, submit a letter of medical necessity with a request for Clinical Exception (Individual Consideration).

Once completed, please fax to: **888-973-0726**

CLINICAL DOCUMENTATION
Copies of clinical documentation that supports the medical necessity criteria for Elzonris must be submitted with this form. **If the patient does not meet all the criteria listed below, please submit a letter of medical necessity explaining why an exception is justified.**

Patient Information	
Patient Name and DOB:	Today's Date:
BCBSMA ID#:	Date of Treatment:

Physician Information	**Facility Information**
Name:	Name:
Address:	Address:
Phone #:	Phone #:
Fax#:	Fax#:
NPI#:	NPI#:

Place of Service: Inpatient ❒ Outpatient ❒

Note:
- Initial treatment cycle **must be** administered in an inpatient setting and individual will be monitored for at least 24 hours after last infusion.
- Subsequent treatment cycles may be administered in an appropriate outpatient setting and additional prior authorization is required.

Please submit clinical documentation to support your request including:
- Clinical background with confirmed diagnosis of BPDCN
- Current labs, ECOG performance score
- Any additional relevant clinical information.