

State of Oklahoma  
Oklahoma Health Care Authority  
**Ixempra® (Ixabepilone) Prior Authorization Form**

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

**Drug Information**

Physician billing (HCPCS code: \_\_\_\_\_)  
**Dose:** \_\_\_\_\_ **Regimen:** \_\_\_\_\_ **Start Date:** \_\_\_\_\_

**Billing Provider Information**

**SoonerCare Provider ID:** \_\_\_\_\_ **Provider Name:** \_\_\_\_\_  
**Provider Phone:** \_\_\_\_\_ **Provider Fax:** \_\_\_\_\_

**Prescriber Information**

**Prescriber NPI:** \_\_\_\_\_ **Prescriber Name:** \_\_\_\_\_  
**Prescriber Phone:** \_\_\_\_\_ **Prescriber Fax:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_

**Criteria**

**For Initial Authorization (Initial approval will be for the duration of 6 months):**

1. Diagnosis of metastatic or locally advanced breast cancer? Yes \_\_\_ No \_\_\_
2. If answer is 'no' from previous question, please indicate diagnosis: \_\_\_\_\_
3. Please indicate the following regarding the usage of ixabepilone:  
Yes \_\_\_ No \_\_\_ Using in combination with capecitabine after failure of an anthracycline and a taxane?  
Yes \_\_\_ No \_\_\_ Using as monotherapy after failure of an anthracycline, a taxane and capecitabine?
4. Please provide dates/dose/duration of previous treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Please provide member's body surface area (m<sup>2</sup>): \_\_\_\_\_

Additional Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For Continued Authorization:**

1. Does member have any evidence of progressive disease while on ixabepilone?  
Yes \_\_\_ No \_\_\_
2. Has the member experienced any adverse drug reactions related to ixabepilone therapy?  
Yes \_\_\_ No \_\_\_

If yes, please specify adverse reactions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization Unit

Fax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4

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