

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

Drug Information

Physician billing (HCPCS code: _____ **) Start Date (or date of next dose):** _____
Dose: _____ **Regimen:** _____

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. Will blinatumomab be used as a single-agent? Yes ___ No ___
2. Please indicate the diagnosis and information:
 - Acute Lymphoblastic Leukemia (ALL)
 - A. What is the Philadelphia chromosome status of the leukemia?
 - Philadelphia chromosome negative (Ph-) ALL
 - Philadelphia chromosome positive (Ph+) ALL
 - Unknown
 - B. Does the patient have relapsed or refractory disease? Yes ___ No ___
 - C. Has member previously failed two Tyrosine Kinase Inhibitors (TKIs)? Yes ___ No ___
 - i. If yes, please list previously failed TKIs: _____
 - D. Will blinatumomab be used as consolidation in patient without substantial comorbidity with persistent or late clearance minimal residual disease positive (MRD+) following a complete response to induction? 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 blinatumomab? Yes ___ No ___
3. Has the member experienced adverse drug reactions related to blinatumomab 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

CONFIDENTIALITY NOTICE

This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.