

**State of Oklahoma  
Oklahoma Health Care Authority  
Synribo® (Omacetaxine) Prior Authorization Form**

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

**Drug Information**

**Pharmacy billing (NDC:** \_\_\_\_\_ **) 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 omacetaxine be used as a single-agent? Yes \_\_\_ No \_\_\_
2. Please indicate the diagnosis and information:
  - Chronic Myeloid Leukemia (CML)
    - a. Primary treatment of advanced phase CML with disease progression to accelerated phase? Yes \_\_\_ No \_\_\_
    - b. Post-hematopoietic stem cell transplant in patient who has relapsed? Yes \_\_\_ No \_\_\_
    - c. Member has T315I mutation? Yes \_\_\_ No \_\_\_
    - d. Member is intolerant or resistant to two or more Tyrosine Kinase Inhibitors (TKIs)? Yes \_\_\_ No \_\_\_
      - i. If yes, please provide additional information regarding TKIs member is intolerant or resistant to: \_\_\_\_\_
  - 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 omacetaxine? Yes \_\_\_ No \_\_\_
  3. Has the member experienced adverse drug reactions related to omacetaxine 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.*

<p>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</p> <p align="center">University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p align="center">Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p align="center"><u>CONFIDENTIALITY NOTICE</u></p> <p><i>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.</i></p>
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