

State of Oklahoma  
Oklahoma Health Care Authority  
**Folotyn® (Pralatrexate) Prior Authorization Form**

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**

Provider NPI: \_\_\_\_\_ Provider Name: \_\_\_\_\_

Provider Phone: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

**Prescriber Information**

Prescriber NPI: \_\_\_\_\_ Prescriber Name: \_\_\_\_\_

Prescriber Phone: \_\_\_\_\_ Prescriber Fax: \_\_\_\_\_ Specialty: \_\_\_\_\_

**Criteria**

**For Initial Authorization:**

- Please indicate the requested information:
  - Will pralatrexate be used as a single-agent? Yes \_\_\_ No \_\_\_
  - Does member have relapsed or refractory disease? Yes \_\_\_ No \_\_\_
- Please indicate the diagnosis and information:
  - Adult T-Cell Leukemia/Lymphoma**
  - Anaplastic Large Cell Lymphoma (ALCL), Primary Cutaneous**
    - Does member have multifocal lesions or regional nodes? Yes \_\_\_ No \_\_\_
    - Will pralatrexate be used as primary treatment? Yes \_\_\_ No \_\_\_
  - Peripheral T-Cell Lymphoma (PTCL)**
  - T-Cell Lymphoma, Extranodal NK/T-Cell Lymphoma, Nasal Type**
    - Does member have relapsed/refractory disease following additional therapy with an alternate combination chemotherapy regimen not previously used? Yes \_\_\_ No \_\_\_
  - Primary Cutaneous Lymphomas – Mycosis Fungoides (MF)/Sézary Syndrome (SS)**
    - Will pralatrexate be used as primary treatment? Yes \_\_\_ No \_\_\_
  - If answer is none of the above, please indicate diagnosis:** \_\_\_\_\_

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

**For Continued Authorization:**

- Date of last dose: \_\_\_\_\_
- Does member have any evidence of progressive disease while on pralatrexate? Yes \_\_\_ No \_\_\_
- Has the member experienced any adverse drug reactions related to pralatrexate therapy? Yes \_\_\_ No \_\_\_  
If yes, please specify adverse reactions: \_\_\_\_\_

**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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