State of Oklahoma
Oklahoma Health Care Authority
Besponsa® (Inotuzumab Ozogamicin) Prior Authorization

SoonerSelect | aetna

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 inotuzumab ozogamicin 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. Is member intolerant/refractory to two or more Tyrosine Kinase Inhibitors (TKIs)? 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 inotuzumab ozogamicin? Yes____ No____
3. Has the member experienced adverse drug reactions related to inotuzumab ozogamicin 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.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/ Oklahoma.	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.*