State of Oklahoma
SoonerCare

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Ixempra® (Ixabepilone) Prior Authorization Form

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

Drug Information

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

Dose:_____ ***Dosing 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:

1. Please indicate the diagnosis and information

☐ **Breast Cancer**

A. Is disease metastatic or locally advanced? Yes☐ No☐

B. Will ixabepilone be used in combination with capecitabine? Yes☐ No☐

i. Has member failed an anthracycline and a taxane? Yes☐ No☐

ii. Is anthracycline contraindicated? Yes☐ No☐

C. Will ixabepilone be used as a single agent? Yes☐ No☐

i. Has member failed capecitabine, an anthracycline, and a taxane? Yes☐ No☐

ii. Has member responded to preoperative systemic therapy? Yes☐ No☐

iii. Has member received at least 1 line of therapy for recurrent unresectable (local or regional) disease? Yes☐ No☐

iv. Is disease human epidermal growth factor receptor 2 (HER2)-negative? Yes☐ No☐

D. Will ixabepilone be used in combination with trastuzumab? Yes☐ No☐

i. Is disease HER2-positive? Yes☐ No☐

ii. Will ixabepilone be used as third-line or subsequent therapy? Yes☐ No☐

☐ **If diagnosis is not listed above, please indicate diagnosis:**_____

Additional Information: _____

For Continued Authorization:

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