OKLAHOMA Health Care Authority

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# State of Oklahoma
# SoonerCare
# Jelmyto® (Mitomycin Pyelocalyceal Solution) 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 (initial approvals will be for once weekly use for the duration of 6 weeks):**

**1. Please indicate the diagnosis and information:**

- ❑ **Urothelial Cancer**
  - A. Is diagnosis non-metastatic upper urinary tract tumor? Yes ☐ No ☐
  - B. Is the tumor a single, residual, low-grade, low-volume (5 to 15mm) tumor? Yes ☐ No ☐
  - C. Is member a candidate for nephroureterectomy? Yes ☐ No ☐
- ❑ **If answer is none of the above, please indicate diagnosis:**____________________________

Additional Information:______________________________________________________________

_____________________________________________________________________________

DRAFT

**For Continued Authorization (continued approval will be for once monthly use for up to 11 additional instillations):**

1. Date of last dose:____________________________
2. Has member experienced complete response 3 months after initial treatment? Yes ☐ No ☐
3. Does member have any evidence of progressive disease while on mitomycin pyelocalyceal solution? Yes ☐ No ☐
4. Has the member experienced adverse drug reactions related to mitomycin pyelocalyceal solution? 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.*

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.**

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