OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Lymphir™ (denileukin diftitox-cxdl) 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:

1. Please indicate the diagnosis and information:
   - ☐ **Cutaneous T-Cell Lymphoma**
     - A. Is diagnosis relapsed or refractory stage I-III cutaneous T-cell lymphoma? Yes ☐ No ☐
     - B. Is there expression of CD25 on ≥20% of malignant cells by immunohistochemistry? Yes ☐ No ☐
     - C. Has the member received at least 1 prior systemic therapy? Yes ☐ No ☐
   - ☐ **If diagnosis is not listed 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 denileukin diftitox-cxdl?
   Yes ☐ No ☐
3. Has the member experienced adverse drug reactions related to denileukin diftitox-cxdl 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.	