State of Oklahoma SoonerCare Ninlaro® (Ixazomib) Prior Authorization Form

OKLAHOMA Health Care Authority | SoonerSelect | aetna

Member Name: ______________________ ***Date of Birth:*** ____________ ***Member ID#:*** ________________

Drug Information

Pharmacy billing **(NDC:**______________________**)** ***Start Date (or date of next dose):*** ____________

Dose: ______________________________________ ***Regimen:*** ________________________________

Billing Provider Information

Pharmacy NPI: ___________________________ ***Pharmacy Name:*** ______________________________

Pharmacy Phone: ________________________ ***Pharmacy Fax:*** ________________________________

Prescriber Information

Prescriber NPI: ____________________ ***Prescriber Name:*** ___________________________________

Prescriber Phone: _______________ ***Prescriber Fax:*** _________________ ***Specialty:*** _________________

Criteria

For Initial Authorization

1. **Please indicate the diagnosis and information**
   - ❑ **Multiple Myeloma**
     - A. Is diagnosis symptomatic multiple myeloma? Yes☐ No☐
     - B. Will ixazomib be used as primary therapy? Yes☐ No☐
     - C. Will ixazomib be used following disease relapse after 6 months following primary induction therapy with the same regimen? Yes☐ No☐
     - D. Will ixazomib be used in combination with lenalidomide and dexamethasone? Yes☐ No☐
     - E. Will ixazomib be used in combination with cyclophosphamide and dexamethasone for a transplant candidate? Yes☐ No☐
     - F. Will ixazomib be used in combination with pomalidomide and dexamethasone after failure with ≥2 prior therapies and disease progression within 60 days? Yes☐ No☐
     - G. Will ixazomib be used as a single-agent for maintenance treatment? Yes☐ No☐
   - ❑ **If diagnosis is not listed above, please indicate diagnosis:**__________________________

Additional Information: ____

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For Continued Authorization:

1. Date of last dose:____________________________
2. Does member have any evidence of progressive disease while on ixazomib? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to ixazomib therapy? Yes☐ No☐

*If yes, please specify adverse reactions:*____

Additional Information: ____

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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.*