OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
Vijoice® (Alpelisib) Prior Authorization Form

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:
   - ☐ **PIK3CA-Related Overgrowth Spectrum (PROS)**
     a. Does member have a documented PIK3CA gene mutation? Yes ☐ No ☐
     b. Does member have severe or life-threatening clinical manifestations of PROS? 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 alpelisib? Yes ☐ No ☐
3. Has the member experienced adverse drug reactions related to alpelisib 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. *Failure to complete this form in full will result in processing delays. Please do not send in chart notes. Specific information will be requested if necessary.*

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.**