

State of Oklahoma  
SoonerCare  
Voranigo<sup>®</sup> (vorasidenib) Prior Authorization Form

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

### Drug Information

Pharmacy Billing (NDC: \_\_\_\_\_) Start Date (or date of next dose): \_\_\_\_\_

Dose: \_\_\_\_\_ Regimen: \_\_\_\_\_

### Pharmacy 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:

- Astrocytoma
- Oligodendroglioma
- Other: \_\_\_\_\_

2. Is diagnosis grade 2 astrocytoma or oligodendroglioma? Yes \_\_\_ No \_\_\_

3. Is there presence of susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation following surgery including biopsy, sub-total resection, or gross total resection? Yes \_\_\_ No \_\_\_

Additional Information: \_\_\_\_\_

#### For Continued Authorization:

1. Date of last dose: \_\_\_\_\_

2. Does member have any evidence of progressive disease while on vorasidenib? Yes \_\_\_ No \_\_\_

3. Has the member experienced adverse drug reactions related to vorasidenib 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.**

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds<sup>®</sup> or SureScripts. All requested data must be provided. Pharmacy Coverage Guidelines are available at [AetnaBetterHealth.com/Oklahoma](http://AetnaBetterHealth.com/Oklahoma).

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