OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
Asparlas® (Calaspargase Pegol-mknl) and Oncaspar® (Pegaspargase) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

❑Physician billing (HCPCS code:_____) ❑Pharmacy billing (NDC:_____)

Dose:_____ Regimen:_____ Start Date (or date of next dose):_____

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:

❑ **Acute Lymphoblastic Leukemia (ALL)**

A. Will the treatment be used as first line therapy? Yes____ No____
B. Will the treatment be used to treat a member with a hypersensitivity to native forms of L-asparaginase? Yes____ No____
C. Will the treatment be used as systemic central nervous system (CNS)-directed therapy? Yes____ No____
D. Will the treatment be used in relapsed/refractory disease? Yes____ No____
   i. If yes, is the disease 1 of the following:
      a. Philadelphia chromosome negative (Ph-)? Yes____ No____
      b. Philadelphia chromosome positive (Ph+)? Yes____ No____
         1. If Ph+, has the member previously received tyrosine kinase inhibitor (TKI) therapy? Yes____ No____
         2. If Ph+, is disease refractory to TKI therapy? Yes___ No___
         3. If Ph+, will treatment be used in conjunction with a TKI? Yes___ No___
E. For Asparlas® (calaspargase pegol-mknl), please provide a patient-specific, clinically significant reason why the member cannot use Oncaspar® (pegaspargase):
   _____

❑ **Extranodal NK/T-Cell Lymphoma**

A. Does member have nasal disease? Yes____ No____
   i. If yes, will this be used as induction therapy? Yes____ No____
   ii. If yes, will this be used as additional therapy in members with a positive biopsy following a partial response or no response to induction therapy? Yes____ No____
B. For Asparlas® (calaspargase pegol-mknl), please provide a patient-specific, clinically significant reason why the member cannot use Oncaspar® (pegaspargase):
   _____

❑ **If answer is none of the above, please indicate diagnosis:**_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on Asparlas® or Oncaspar®? Yes___ No___
3. Has the member experienced adverse drug reactions related to Asparlas® or Oncaspar® 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.

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.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE