OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Scemblix® (Asciminib) Prior Authorization Form

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:**

❑ **Chronic Myeloid Leukemia (CML)**

A. Is diagnosis Philadelphia chromosome-positive (Ph+) CML in chronic phase? Yes____ No____

i. Has member been previously treated with ≥2 tyrosine kinase inhibitors? Yes____ No____

ii. Will Scemblix® be used as frontline or subsequent therapy in CML with the T315I mutation? 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 asciminib? Yes____ No____
3. Has the member experienced adverse drug reactions related to asciminib 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 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