OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Besremi® (Ropeginterferon Alfa-2b-njft) 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:**
   - ❑ **Polycythemia Vera**
     A. Will Besremi® be used as a single agent? 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 Besremi® ? Yes____ No____
3. Has the member experienced adverse drug reactions related to Besremi® 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