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 a component of multi-agent chemotherapy? Yes☐ No☐
B. 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:_____**

Additional Information:_____

_____

_____

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:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*