SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Copiktra™ (Duvelisib) 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

***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:

☐ **Follicular Lymphoma (FL)**

A. Will duvelisib be used for relapsed or refractory disease? Yes____ No____
B. Will duvelisib be used as a single agent? Yes____ No____
C. Will duvelisib be used for disease progression following two or more lines of systemic therapy? Yes____ No____

☐ **Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)**

A. Will duvelisib be used for relapsed or refractory disease? Yes____ No____
B. Will duvelisib be used as a single agent? Yes____ No____
C. Will duvelisib be used for disease progression following two or more lines of systemic therapy? Yes____ No____

☐ **If diagnosis is not listed above, please indicate diagnosis**: ________________________________

Additional Information:____

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For Continued Authorization:

1. Date of last dose:_____________________________
2. Does member have any evidence of progressive disease while on duvelisib? Yes____ No____
3. Has the member experienced any adverse drug reactions related to duvelisib therapy? Yes____ No____

*If yes, please specify adverse reactions:*____

Additional Information:____

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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.*