State of Oklahoma
SoonerCare
Ninlaro® (Ixazomib) 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**
   - ❑ **Multiple Myeloma**
     - A. Is diagnosis symptomatic multiple myeloma? Yes☐ No☐
     - B. Will ixazomib be used as primary therapy? Yes☐ No☐
     - C. Will ixazomib be used following disease relapse after 6 months following primary induction therapy with the same regimen? Yes☐ No☐
     - D. Will ixazomib be used in combination with lenalidomide and dexamethasone? Yes☐ No☐
     - E. Will ixazomib be used in combination with cyclophosphamide and dexamethasone for a transplant candidate? Yes☐ No☐
     - F. Will ixazomib be used in combination with pomalidomide and dexamethasone after failure with ≥2 prior therapies and disease progression within 60 days? Yes☐ No☐
     - G. Will ixazomib be used as a single-agent for maintenance treatment? 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 ixazomib? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to ixazomib 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. *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