OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Iclusig® (Ponatinib) 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 (Initial approval will be for the duration of 6 months):

1. Please indicate diagnosis and information:
   - ☐ Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia (ALL)
     - A. Induction/consolidation with HyperCVAD? Yes ☐ No ☐
     - B. Maintenance therapy in combination with vincristine and prednisone, with or without methotrexate and mercaptopurine? Yes ☐ No ☐
     - C. Maintenance therapy post-hematopoietic stem cell transplant? Yes ☐ No ☐
     - D. Relapsed/refractory disease either as a single-agent, in combination with chemotherapy not previously given, or in patients with T315I mutations? Yes ☐ No ☐
   - ☐ Chronic Myeloid Leukemia (CML)
     - A. T315I mutation? Yes ☐ No ☐
     - B. Intolerant or resistant to 2 or more tyrosine kinase inhibitors (TKIs)? Yes ☐ No ☐
       - i. If yes, please list the TKIs: _____
       - ii. Please provide additional information describing the member's intolerance/ resistance: _____
     - C. Post-hematopoietic stem cell transplantation in member with prior accelerated or blast phase prior to transplant or who have relapsed? Yes ☐ No ☐
   - ☐ Other, please provide diagnosis: _____

Additional Information: _____

_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on ponatinib? Yes ☐ No ☐
3. Has the member experienced adverse drug reactions related to ponatinib 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:

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