SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Zydelig® (Idelalisib) 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. Will idelalisib be used as second-line or subsequent therapy? Yes ☐ No ☐
2. Will idelalisib be used for relapsed or refractory disease? Yes ☐ No ☐
3. Please indicate the diagnosis and information:
   - ☐ Follicular Lymphoma (FL)
     - A. Is diagnosis Grade 1 to Grade 2 follicular lymphoma? Yes ☐ No ☐
     - B. Refractory to alkylator therapy? Yes ☐ No ☐
     - C. Refractory to rituximab therapy? Yes ☐ No ☐
   - ☐ Gastric or Nongastric Mucosa-Associated Lymphoid Tissue (MALT) Lymphoma, Nodal or Splenic Marginal Zone Lymphoma (MZL)
     - A. Refractory to alkylator therapy? Yes ☐ No ☐
     - B. Refractory to rituximab therapy? Yes ☐ No ☐
   - ☐ Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)
     - A. Will idelalisib be used as a single agent? Yes ☐ No ☐
     - B. Will idelalisib be used in combination with rituximab or rituximab/bendamustine? 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 idelalisib? Yes ☐ No ☐
3. Has the member experienced any adverse drug reactions related to idelalisib 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