SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Ixempra® (Ixabepilone) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

❑ Physician billing (HCPCS code:_____)

Dose: _____ ***Regimen:*** _____ ***Start Date:*** _____

Billing Provider Information

SoonerCare Provider ID: _____ ***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. Diagnosis of metastatic or locally advanced breast cancer? Yes____ No_____
2. If answer is 'no' from previous question, please indicate diagnosis: _____
3. Please indicate the following regarding the usage of ixabepilone:
   Yes____ No____ Using in combination with capecitabine after failure of an anthracycline and a taxane?
   Yes____ No____ Using as monotherapy after failure of an anthracycline, a taxane and capecitabine?
4. Please provide dates/dose/duration of previous treatment: _____
   _____
   _____
5. Please provide member's body surface area (m^2): _____

Additional Information: _____
_____

For Continued Authorization:

1. Does member have any evidence of progressive disease while on ixabepillone?
   Yes____ No____
2. Has the member experienced any adverse drug reactions related to ixabepilone 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