SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority

# Imlygic® (Talimogene) 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 melanoma? Yes ___ No___
   A. If answer is 'yes' to question 1, please provide following information:
      i. Does member have unresectable cutaneous, subcutaneous, or nodal lesions that are recurrent after initial surgery? Yes ___ No___
      ii. Does member have visceral metastases? Yes ___ No___
2. If answer is 'no' to question 1, please indicate diagnosis:______________________________
3. Please indicate requested information:
   A. Is the member immunocompromised? Yes ___ No___
   B. For women of childbearing potential—Is the member pregnant? Yes ___ No___

Additional Information: ____________________________________________________________________

__________________________________________________________________________________________

**For Continued Authorization:**

1. Does member have any evidence of progressive disease while on talimogene? Yes____ No____
2. Has member experienced adverse drug reactions related to talimogene 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: | CONFIDENTIALITY NOTICE |
|---|---|
| University of Oklahoma College of Pharmacy<br>Pharmacy Management Consultants<br>Product Based Prior Authorization Unit<br><br>Fax: 1-800-224-4014<br>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.* |