SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Besponsa® (Inotuzumab Ozogamicin) Prior Authorization

Member Name: ______________________ ***Date of Birth:***______________ ***Member ID#:***_________________

Drug Information

❑ Physician billing (HCPCS code:________________) ***Start Date (or date of next dose):*** ______________
Dose: ______________________________________ ***Regimen:*** ___________________________________

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. Will inotuzumab ozogamicin be used as a single-agent? Yes ___ No___
2. Please indicate the diagnosis and information:
   - ☐ Acute Lymphoblastic Leukemia (ALL)
     - A. What is the Philadelphia chromosome status of the leukemia?
       - ☐ Philadelphia chromosome negative (Ph-) ALL
       - ☐ Philadelphia chromosome positive (Ph+) ALL
       - ☐ Unknown
     - B. Does the patient have relapsed or refractory disease? Yes ___ No___
     - C. Is member intolerant/refractory to two or more Tyrosine Kinase Inhibitors (TKIs)? Yes ___ No___
   - ☐ If answer is none of the 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 inotuzumab ozogamicin? Yes____ No____
3. Has the member experienced adverse drug reactions related to inotuzumab ozogamicin 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 Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 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.*