SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Blincyto® (Blinatumomab) Prior Authorization Form

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

Drug Information

❑ ***Physician billing*** **(HCPCS code:** _____**)** ❑ ***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 blinatumomab 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. Has member previously failed two Tyrosine Kinase Inhibitors (TKIs)? Yes☐ No☐
       - i. If yes, please list previously failed TKIs: _____
     - D. Will blinatumomab be used as consolidation in patient without substantial comorbidity with persistent or late clearance minimal residual disease positive (MRD+) following a complete response to induction? 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 blinatumomab? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to blinatumomab 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.*