SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Iclusig® (Ponatinib) 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. Please indicate diagnosis and information:
   - ☐ Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia (ALL)
     - A. Induction/consolidation with HyperCVAD? Yes____ No____
     - B. Maintenance therapy in combination with vincristine and prednisone, with or without metho-trexate and mercaptopurine? Yes____ No____
     - C. Maintenance therapy post-hematopoietic stem cell transplant? Yes____ No____
     - D. Relapsed/refractory disease either as a single-agent, in combination with chemotherapy not previously given, or in patients with T315I mutations? Yes____ No____
   - ☐ Chronic Myeloid Leukemia (CML)
     - A. T315I mutation? Yes____ No____
     - B. Intolerant or resistant to all other Tyrosine Kinase Inhibitors (TKIs)? Yes____ No____
       - i. If yes, please provide additional information regarding TKIs member is intolerant or resistant to:_____
     - C. Post-hematopoietic stem cell transplantation in patient with prior accelerated or blast phase prior to transplant or who have relapsed? Yes____ No____
   - ☐ Other, please provide diagnosis:_____

Additional Information:_____

_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on ponatinib? Yes____ No____
3. Has the member experienced adverse drug reactions related to ponatinib therapy? Yes____ No____

*If yes, please specify adverse reactions:*_____

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