SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Beleodaq® (Belinostat) Prior Authorization Form

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

Provider NPI:_____ ***Provider Name:***_____
Provider Phone:_____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____
Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Criteria

For Initial Authorization:

1. Please indicate the requested information:
   A. Will belinostat be used as a single-agent? Yes☐ No☐
2. Please indicate the diagnosis and information:
   - ❑ **Anaplastic Large Cell Lymphoma (ALCL), Primary Cutaneous**
     A. Will belinostat be used for primary treatment or in relapsed/refractory disease with multifocal lesions, or cutaneous ALCL with regional nodes? Yes☐ No☐
   - ❑ **Primary Cutaneous Lymphomas – Mycosis Fungoides (MF)/Sézary Syndrome (SS)**
     A. Will belinostat be used for primary treatment in Stage IV non Sézary or visceral disease (solid organ) with or without radiation therapy for local control? Yes☐ No☐
     B. Will belinostat be used for primary treatment for large cell transformation with generalized cutaneous or extracutaneous lesions with or without skin-directed therapy? Yes☐ No☐
     C. Will belinostat be used in relapsed/refractory disease with or without skin-directed therapy? Yes☐ No☐
   - ❑ **Peripheral T-Cell Lymphoma (PTCL)**
     A. Will belinostat be used in relapsed/refractory disease? Yes☐ No☐
   - ❑ **Adult T-Cell Leukemia/Lymphoma**
     A. Will belinostat be used in relapsed/refractory disease? Yes☐ No☐
   - ❑ **T-Cell Lymphoma, Extranodal NK/T-Cell Lymphoma, Nasal Type**
     A. Will belinostat be used in relapsed/refractory disease following additional therapy with an alternate combination chemotherapy regimen not previously used? Yes☐ No☐
   - ❑ **If answer is none of the above, please indicate diagnosis:**_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on belinostat? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to belinostat 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:	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.*