



State of Oklahoma
 SoonerCare
Asparlas™ (Calaspargase Pegol-mknl)
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 diagnosis and information:

Acute Lymphoblastic Leukemia (ALL)

A. Please provide a patient-specific, clinically significant reason why the member cannot use Oncaspar® (pegaspargase): _____

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 calaspargase pegol-mknl?
 Yes ___ No ___

3. Has the member experienced adverse drug reactions related to calaspargase pegol-mknl 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

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