OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

Ixempra® (Ixabepilone) Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code:_____**)** ***Start Date (or date of next dose):***_____

Dose:_____ ***Dosing 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

- ❑ **Breast Cancer**
  - A. Is disease metastatic or locally advanced? Yes____ No____
  - B. Will ixabepilone be used in combination with capecitabine? Yes____ No____
    - i. Has member failed an anthracycline and a taxane? Yes____ No____
    - ii. Is anthracycline contraindicated? Yes____ No____
  - C. Will ixabepilone be used as a single agent? Yes____ No____
    - i. Has member failed capecitabine, an anthracycline, and a taxane? Yes____ No____
    - ii. Has member responded to preoperative systemic therapy? Yes____ No____
    - iii. Has member received at least 1 line of therapy for recurrent unresectable (local or regional) disease? Yes____ No____
    - iv. Is disease human epidermal growth factor receptor 2 (HER2)-negative? Yes____ No____
  - D. Will ixabepilone be used in combination with trastuzumab? Yes____ No____
    - i. Is disease HER2-positive? Yes____ No____
    - ii. Will ixabepilone be used as third-line or subsequent therapy? Yes____ No____
- ❑ **If diagnosis is not listed above, please indicate diagnosis:**_____

Additional Information: _____

For Continued Authorization:

1. Does member have any evidence of progressive disease while on ixabepillone? Yes____ No____
2. Has the member experienced any adverse drug reactions related to ixabepilone 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. *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.*