SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Synribo® (Omacetaxine) 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

SoonerCare Provider ID:_____ ***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 omacetaxine be used as a single-agent? Yes ___ No___
2. Please indicate the diagnosis and information:
   - ☐ Chronic Myeloid Leukemia (CML)
     a. Primary treatment of advanced phase CML with disease progression to accelerated phase? Yes ___ No___
     b. Post-hematopoietic stem cell transplant in patient who has relapsed? Yes ___ No___
     c. Member has T315I mutation? Yes ___ No___
     d. Member is intolerant or resistant to two or more Tyrosine Kinase Inhibitors (TKIs)? Yes ___ No___
        i. If yes, please provide additional information regarding TKIs member is intolerant or resistant to:_____
   - ☐ 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 omacetaxine? Yes____ No____
3. Has the member experienced adverse drug reactions related to omacetaxine 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.*