

State of Oklahoma  
SoonerCare  
**Idhifa® (Enasidenib) 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**

Pharmacy NPI: \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

**Prescriber Information**

Prescriber NPI: \_\_\_\_\_ Prescriber Name: \_\_\_\_\_

Prescriber Phone: \_\_\_\_\_ Prescriber Fax: \_\_\_\_\_ Specialty: \_\_\_\_\_

**Criteria**

**For Initial Authorization:**

**1. Please indicate the diagnosis and information:**

**Acute Myeloid Leukemia (AML)**

- A. Is AML newly-diagnosed? Yes \_\_\_ No \_\_\_
  - i. Does member have comorbidities that preclude use of intensive chemotherapy?  
Yes \_\_\_ No \_\_\_
  - ii. Will Idhifa® (enasidenib) be used as a single-agent? Yes \_\_\_ No \_\_\_
  - iii. Has an IDH2 mutation been detected? Yes \_\_\_ No \_\_\_
- B. Is AML relapsed or refractory? Yes \_\_\_ No \_\_\_
  - i. Will Idhifa® (enasidenib) be used as a single-agent? Yes \_\_\_ No \_\_\_
  - ii. Has an IDH2 mutation been detected? Yes \_\_\_ No \_\_\_

**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 enasidenib? Yes \_\_\_ No \_\_\_
- 3. Has the member experienced adverse drug reactions related to enasidenib 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

*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.*