OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Anktiva® (nogapendekin alfa inbakicept-pmln) Prior Authorization Form

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

Drug Information

☐ ***Physician billing (HCPCS code:_____)*** ☐ ***Pharmacy billing (NDC:_____)***

Dose:_____ Regimen:_____ Start Date (or date of next dose):_____

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: *(initial approvals will be for 6 induction doses)*

1. Please indicate the diagnosis and information:
   - ☐ **Non-Muscle Invasive Bladder Cancer (NMIBC)**
     - A. Does member have a diagnosis of NMIBC with carcinoma in situ (CIS)? Yes ☐ No ☐
     - B. Is cancer unresponsive to initial Bacillus Calmette-Guerin (BCG) therapy? Yes ☐ No ☐
     - C. Will Anktiva® be used in conjunction with BCG? Yes ☐ No ☐
   - ☐ **If diagnosis is not listed above, please indicate diagnosis**: _____

Additional Information: _____

_____

For Continued Authorization:

1. Date of last dose: _____
2. Has the member had a complete response to induction dosing? Yes ☐ No ☐
   a. If yes, is the current request for maintenance dosing? Yes ☐ No ☐
   b. If no, is the current request for a second induction course? Yes ☐ No ☐
3. Does member have any evidence of disease recurrence or progression while on Anktiva®? Yes ☐ No ☐
4. Has member experienced adverse drug reactions related to Anktiva® therapy? Yes ☐ No ☐
   a. 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. *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.*