

Turalio™ (Pexidartinib) Prior Authorization Form

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

Drug Information

Pharmacy billing (NDC: _____ **) Start Date (or date of next dose):** _____

Dose: _____ **Regimen:** _____

Pharmacy 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 diagnosis and information:

Soft Tissue Sarcoma – Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor

A. Is member a candidate for surgery? Yes ___ No ___

B. Will pexidartinib be used as a single-agent? Yes ___ No ___

Other, please provide diagnosis: _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on pexidartinib? Yes ___ No ___

3. Has member experienced adverse drug reactions related to pexidartinib 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:

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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