OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Elzonris® (Tagraxofusp-erzs) Prior Authorization Form

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

Drug Information

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

Dose:_____ 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. Is diagnosis blastic plasmacytoid dendritic cell neoplasm (BPDCN)? Yes☐ No☐
2. Will tagraxofusp be used as a single-agent? Yes☐ No☐
3. If diagnosis is NOT blastic plasmacytoid dendritic cell neoplasm (BPDCN), please indicate diagnosis:

_____

Additional Information:_____

_____

For Continued Authorization:

1. Date of last dose:_____
2. Does patient have any evidence of progressive disease while on tagraxofusp therapy? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to tagraxofusp 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