OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Jelmyto® (Mitomycin Pyelocalyceal Solution)
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 (initial approvals will be for once weekly use for the duration of 6 weeks):

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

☐ **Urothelial Cancer**

A. Is diagnosis non-metastatic upper urinary tract tumor? Yes☐ No☐

B. Is the tumor a single, residual, low-grade, low-volume (5 to 15mm) tumor? Yes☐ No☐

C. Is member a candidate for nephroureterectomy? Yes☐ No☐

☐ **If answer is none of the above, please indicate diagnosis:**_____

Additional Information:_____

_____

For Continued Authorization (continued approval will be for once monthly use for up to 11 additional instillations):

1. Date of last dose:_____
2. Has member experienced complete response 3 months after initial treatment? Yes☐ No☐
3. Does member have any evidence of progressive disease while on mitomycin pyelocalyceal solution? Yes☐ No☐
4. Has the member experienced adverse drug reactions related to mitomycin pyelocalyceal solution? 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

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