OKLAHOMA Health Care Authority

# State of Oklahoma SoonerCare
# Blincyto® (Blinatumomab) 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 (Initial approval will be for the duration of 6 months):**

1. Will blinatumomab be used as a single-agent? Yes☐ No☐
2. Please indicate the diagnosis and information:
   - ☐ **Acute Lymphoblastic Leukemia (ALL)**
     - A. What is the Philadelphia chromosome status of the leukemia?
       - ☐ Philadelphia chromosome negative (Ph-) ALL
       - ☐ Philadelphia chromosome positive (Ph+) ALL
       - ☐ Unknown
     - B. Does the patient have relapsed or refractory disease? Yes☐ No☐
     - C. Has member previously failed two Tyrosine Kinase Inhibitors (TKIs)? Yes☐ No☐
       - i. If yes, please list previously failed TKIs: _____
     - D. Will blinatumomab be used as consolidation in patient without substantial comorbidity with persistent or late clearance minimal residual disease positive (MRD+) following a complete response to induction? 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 blinatumomab? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to blinatumomab 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