OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Besremi® (ropeginterferon alfa-2b-njft) 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 the diagnosis and information:
   - ☐ Polycythemia Vera
   - ☐ Essential Thrombocythemia
   - ☐ Other:_____
2. Will Besremi® be used as a single agent? Yes☐ No☐

Additional Information:_____

_____

_____

_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on Besremi®? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to Besremi® 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. *Failure to complete this form in full will result in processing delays. Please do not send in chart notes. They will be requested if necessary.*

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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