OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Omisirge® (omidubicel-onlv) Prior Authorization Form

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

Drug Information

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

Dose:_____ Dosing 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. Please include the most recent office visit note or clinical summary from the hospital to support your request.
   Is this information attached? Yes☐ No☐
2. Will omidubicel-onlv be used to reduce time to neutrophil recovery and incidence of infection? Yes☐ No☐
3. Please indicate the diagnosis and information:

☐ **Hematological Malignancy** (Please specify: _____)

A. Is an allogeneic stem cell transplant using an umbilical cord blood donor source planned? Yes☐ No☐
   i. If yes, documentation of the donor source must be provided: _____
   _____

B. Will a myeloablative conditioning regimen be used? Yes☐ No☐
   i. If yes, documentation of the member's conditioning regimen must be provided: _____
   _____

☐ **Severe Aplastic Anemia**

A. Is an allogeneic stem cell transplant using an umbilical cord blood donor source planned? Yes☐ No☐
   i. If yes, documentation of the donor source must be provided: _____
   _____
   ii. Is a compatible donor available? Yes☐ No☐

B. Will a reduced intensity conditioning regimen be used? Yes☐ No☐
   i. If yes, documentation of the member's conditioning regimen must be provided: _____
   _____

☐ **Other:** _____

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 PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*