OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

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Asparlas® (Calaspargase Pegol-mknl) and Oncaspar® (Pegaspargase) Prior Authorization Form

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

Drug Information

☐**Physician billing (HCPCS code:** _____**)** ☐**Pharmacy billing (NDC:** _____**)**

Dose: _____ ***Regimen:*** _____ ***Start Date (or date of next dose):*** _____

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 indicate the diagnosis and information:**

☐ **Acute Lymphoblastic Leukemia (ALL)**

A. Will the treatment be used as first line therapy? Yes☐ No☐
B. Will the treatment be used to treat a member with a hypersensitivity to native forms of L-asparaginase? Yes☐ No☐
C. Will the treatment be used as systemic central nervous system (CNS)-directed therapy? Yes☐ No☐
D. Will the treatment be used in relapsed/refractory disease? Yes☐ No☐
   i. If yes, is the disease 1 of the following:
      a. Philadelphia chromosome negative (Ph-)? Yes☐ No☐
      b. Philadelphia chromosome positive (Ph+)? Yes☐ No☐
         1. If Ph+, has the member previously received tyrosine kinase inhibitor (TKI) therapy? Yes☐ No☐
         2. If Ph+, is disease refractory to TKI therapy? Yes☐ No☐
         3. If Ph+, will treatment be used in conjunction with a TKI? Yes☐ No☐
E. For Asparlas® (calaspargase pegol-mknl), please provide a patient-specific, clinically significant reason why the member cannot use Oncaspar® (pegaspargase):

_____

☐ **Extranodal NK/T-Cell Lymphoma**

A. Does member have nasal disease? Yes☐ No☐
   i. If yes, will this be used as induction therapy? Yes☐ No☐
   ii. If yes, will this be used as additional therapy in members with a positive biopsy following a partial response or no response to induction therapy? Yes☐ No☐
B. For Asparlas® (calaspargase pegol-mknl), please provide a patient-specific, clinically significant reason why the member cannot use Oncaspar® (pegaspargase):

_____

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

For Continued Authorization:

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

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**