

Beleodaq® (belinostat) 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:**

1. Please indicate the requested information:

A. Will belinostat be used as a single-agent? Yes No

2. Please indicate the diagnosis and information:

 Anaplastic Large Cell Lymphoma (ALCL), Primary CutaneousA. Will belinostat be used for primary treatment or in relapsed/refractory disease with multifocal lesions, or cutaneous ALCL with regional nodes? Yes No **Peripheral T-Cell Lymphoma (PTCL)**A. Will belinostat be used for initial palliative intent or in relapsed/refractory disease? Yes No **Adult T-Cell Leukemia/Lymphoma**A. Will belinostat be used in relapsed/refractory disease? Yes No **T-Cell Lymphoma, Extranodal NK/T-Cell Lymphoma, Nasal Type**A. Will belinostat be used in relapsed/refractory disease following additional therapy with an alternate combination chemotherapy regimen (asparaginase-based) not previously used? Yes No **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 belinostat? Yes No 3. Has the member experienced any adverse drug reactions related to belinostat therapy? Yes No

If yes, please specify adverse reactions: _____

Additional Information: _____

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.**CONFIDENTIALITY NOTICE***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.*