OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

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Blincyto® (blinatumomab) 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 (Initial approval will be for the duration of 6 months):

1. Please indicate the diagnosis and information:

☐ **Philadelphia Chromosome-Negative (Ph-) Acute Lymphoblastic Leukemia (ALL)**

A. How will blinatumomab be used?

- ☐ As consolidation therapy as a component of multiphase chemotherapy
- ☐ As consolidation in adolescents/young adults or adults younger than 65 years of age without substantial comorbidity with persistent or late clearance minimal residual disease positive (MRD+) following a complete response to induction.
- ☐ As maintenance therapy in combination with mercaptopurine, vincristine, methotrexate, and prednisone (POMP) as a component of maintenance.
- ☐ For management of relapsed/refractory Ph– ALL.
- ☐ Other: _____

☐ **Philadelphia Chromosone-Positive (Ph+) Acute Lymphoblastic Leukemia (ALL)**

A. How will blinatumomab be used?

- ☐ In combination with with a tyrosine kinase inhibitor (TKI) as frontline consolidation if not a candidate for multiagent chemotherapy.
- ☐ With or without a TKI as consolidation in adolescents/young adults or adults younger than 65 years of age without substantial comorbidity with persistent or late clearance MRD+ following a complete response to induction.
- ☐ As maintenance therapy in combination with POMP as a component of maintenance therapy if refractory to TKIs.
- ☐ For management of relapsed/refractory Ph+ ALL after failure of 2 TKIs.
- ☐ Other: _____

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

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.

Blincyto® (blinatumomab) Prior Authorization Form

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

Criteria

For Initial Authorization: ***(continued)***

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.

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