

**Copiktra® (duvelisib) 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:

**Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)**

A. Will duvelisib be used for relapsed or refractory disease? Yes  No

B. Will duvelisib be used as a single agent? Yes  No

C. Will duvelisib be used for disease progression following two or more lines of systemic therapy? Yes  No

**Peripheral T-Cell Lymphomas (PTCL)**

A. Will duvelisib be used as a single agent or in combination with romidepsin? Yes  No

**If diagnosis is not listed above, please indicate diagnosis:** \_\_\_\_\_

**Additional Information:** \_\_\_\_\_

**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_

2. Does member have any evidence of progressive disease while on duvelisib? Yes  No

3. Has the member experienced adverse drug reactions related to duvelisib 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.***

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](http://AetnaBetterHealth.com/Oklahoma).

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