OKLAHOMA Health Care Authority

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State of Oklahoma
SoonerCare
Idhifa® (enasidenib) 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. Will enasidenib be used as a single agent? Yes☐ No☐
2. Has an isocitrate dehydrogenase-2 (IDH2) mutation been detected? Yes☐ No☐
3. Please indicate the diagnosis and information:
   - ☐ **Acute Myeloid Leukemia (AML)**
     - A. Is AML newly-diagnosed? Yes☐ No☐
       - i. Is member unable to tolerate intensive induction chemotherapy? Yes☐ No☐
     - B. Is AML relapsed or refractory? Yes☐ No☐
   - ☐ **Other:** _____

Additional Information: _____

_____

For Continued Authorization:

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