State of Oklahoma **SoonerCare**





Ixempra® (Ixabepilone) Prior Authorization Form

Date of Birth:	Member ID#:
Drug Information	
:) Start Da	te (or date of next dose):
Dose: Dosing Regimen:	
Billing Provider Information	
Provider Nam	ne:
Provider Fax:_	
Prescriber Information	
Prescriber Name:	
Prescriber Fax:	Specialty:
Criteria	
For Initial Authorization: 1. Please indicate the diagnosis and information Breast Cancer A. Is disease metastatic or locally advanced? Yes No B. Will ixabepilone be used in combination with capecitabine? Yes No i. Has member failed an anthracycline and a taxane? Yes No ii. Is anthracycline contraindicated? Yes No C. Will ixabepilone be used as a single agent? Yes No i. Has member failed capecitabine, an anthracycline, and a taxane? Yes No ii. Has member responded to preoperative systemic therapy? Yes No iii. Has member received at least 1 line of therapy for recurrent unresectable (local or regional) disease? Yes No iv. Is disease human epidermal growth factor receptor 2 (HER2)-negative? Yes No D. Will ixabepilone be used in combination with trastuzumab? Yes No i. Is disease HER2-positive? Yes No ii. Will ixabepilone be used as third-line or subsequent therapy? Yes No diagnosis is not listed above, please indicate diagnosis: Additional Information: For Continued Authorization: 1. Does member have any evidence of progressive disease while on ixabepillone? Yes No 2. Has the member experienced any adverse drug reactions related to ixabepillone therapy? Yes No If yes, please specify adverse reactions:	
	Date:
	Drug Information Dosing Regiment Billing Provider Inform Provider Fax: Prescriber Informat Prescriber Name: Prescriber Fax: Criteria Criteria osis and information tic or locally advanced? Yes_ used in combination with cape and a taxa contraindicated? Yes_ used as a single agent? Yes_ ed capecitabine, an anthracycle and a to preoperative system be a caped at least 1 line of therapy and a pidermal growth factor recompanies of the combination with trastrative and the combination w

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.

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