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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION JOENJA® (leniolisib)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

For initial approval, complete the following questions to receive a 1-year approval:

1. Is the member 12 years of age or older and weighing ≥ 45 kg? **AND**
   ☐ Yes ☐ No

2. Does the member have a confirmed diagnosis of activated phosphoinositide 3-kinase delta (PI3Kδ) syndrome (APDS), as demonstrated by the presence of an APDS-associated genetic PI3Kδ mutation with a documented variant in either *PIK3CD* or *PIK3R1*? **AND**
   ☐ Yes ☐ No

3. Does the member have nodal and/or extra-nodal lymphoproliferation, with the presence of ≥ 1 measurable nodal lesion, as measured on computed tomography (CT) or magnetic resonance imaging (MRI) **OR** have clinical findings and manifestations compatible with APDS (e.g., history of repeated oto-sino-pulmonary infections, organ dysfunction [e.g., lung, liver])? **AND**
   ☐ Yes ☐ No

4. Has pregnancy status been confirmed in individuals of reproductive potential prior to initiating therapy and highly effective methods of contraception will be used during treatment? **AND**
   ☐ Yes ☐ No

5. Will the member avoid concomitant therapy with all the following:
   - Coadministration with strong and moderate CYP3A4 inducers (e.g., rifampin, bosentan, efavirenz, etravirine, St. John's Wort); **AND**
   - Coadministration with strong CYP3A4 inhibitors (e.g., itraconazole, ketoconazole, clarithromycin)? **AND**

   ☐ Yes ☐ No

6. Will the member avoid concurrent immunosuppressive therapy (e.g., mammalian target of rapamycin (mTOR) inhibitors, B-cell depleters, glucocorticoids [doses > 25 mg/day of prednisone equivalent], cyclophosphamide, mycophenolate)?
   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

For renewal, complete the following questions to receive a 1-year approval:

7. Does the member continue to meet the above criteria? **AND**
   ☐ Yes ☐ No

8. Does the member have disease response with treatment as defined by stabilization of or improvement of disease signs and symptoms? **AND**
   ☐ Yes ☐ No

9. Has the member been assessed for toxicity?
   ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.