

## State of Oklahoma SoonerCare





## Asparlas<sup>®</sup> (Calaspargase Pegol-mknl) and Oncaspar<sup>®</sup> (Pegaspargase) Prior Authorization Form

Prescriber NPI:	Member Na	me:	Date of Birth:	Member ID#:
Billing Provider Information			<b>Drug Information</b>	
Provider NPI:	□Physicia	n billing (HCPCS code:	)   □Pharmacy b	villing (NDC:)
Provider NPI:	Dose:	Regimen:	Regimen: Start Date (or date of next dose):	
Provider NPI:			Billing Provider Informa	ation
Prescriber NPI:	Provider N			
Prescriber NPI:	Provider P	hone:	Provider Fax:	
Prescriber NPI:			Prescriber Information	on
Criteria  for Initial Authorization: Please indicate the diagnosis and information: Acute Lymphoblastic Leukemia (ALL) A. Will the treatment be used as first line therapy? Yes No B. Will the treatment be used to treat a member with a hypersensitivity to native forms of L-asparaginase? Yes No C. Will the treatment be used as systemic central nervous system (CNS)-directed therapy? Yes No D. Will the treatment be used in relapsed/refractory disease? Yes No i. If yes, is the disease 1 of the following: a. Philadelphia chromosome negative (Ph-)? Yes No b. Philadelphia chromosome positive (Ph+)? Yes No 1. If Ph+, has the member previously received tyrosine kinase inhibitor (TKI) therapy? Yes No 2. If Ph+, will treatment be used in conjunction with a TKI? Yes No 3. If Ph+, will treatment be used in conjunction with a TKI? Yes No E. For Asparlas® (calaspargase pegol-mknl), please provide a patient-specific, clinically significant reason we the member cannot use Oncaspar® (pegaspargase):    Extranodal NK/T-Cell Lymphoma	Prescriber	NPI:	Prescriber Name:	
For Initial Authorization:  Please indicate the diagnosis and information:  Acute Lymphoblastic Leukemia (ALL)  A. Will the treatment be used as first line therapy? Yes No B. Will the treatment be used to treat a member with a hypersensitivity to native forms of L-asparaginase? Yes No C. Will the treatment be used as systemic central nervous system (CNS)-directed therapy? Yes No D. Will the treatment be used in relapsed/refractory disease? Yes No i. If yes, is the disease 1 of the following:  a. Philadelphia chromosome negative (Ph-)? Yes No b. Philadelphia chromosome positive (Ph+)? Yes No 1. If Ph+, has the member previously received tyrosine kinase inhibitor (TKI) therapy? Yes No 2. If Ph+, is disease refractory to TKI therapy? Yes No 2. If Ph+, will treatment be used in conjunction with a TKI? Yes No E. For Asparlas® (calaspargase pegol-mknl), please provide a patient-specific, clinically significant reason we the member cannot use Oncaspar® (pegaspargase):  Extranodal NK/T-Cell Lymphoma A. Does member have nasal disease? Yes No i. If yes, will this be used as induction therapy? Yes No B. For Asparlas® (calaspargase pegol-mknl), please provide a patient-specific, clinically significant reason we the member cannot use Oncaspar® (pegaspargase):  If answer is none of the above, please indicate diagnosis: For Continued Authorization: Date of last dose: Does member have any evidence of progressive disease while on Asparlas® or Oncaspar®? Yes No Has the member experienced adverse drug reactions related to Asparlas® or Oncaspar® therapy? Yes No Has the member experienced adverse drug reactions related to Asparlas® or Oncaspar® therapy? Yes No	Prescriber	Phone: F	Prescriber Fax:	Specialty:
or Initial Authorization:  Please indicate the diagnosis and information:  Acute Lymphoblastic Leukemia (ALL)  A. Will the treatment be used as first line therapy? YesNo			Criteria	
response or no response to induction therapy? Yes No B. For Asparlas® (calaspargase pegol-mknl), please provide a patient-specific, clinically significant reason w the member cannot use Oncaspar® (pegaspargase):  If answer is none of the above, please indicate diagnosis:  or Continued Authorization: Date of last dose: Does member have any evidence of progressive disease while on Asparlas® or Oncaspar®? Yes No Has the member experienced adverse drug reactions related to Asparlas® or Oncaspar® therapy? Yes No	A.B.	Will the treatment be used as fit Will the treatment be used to treatment be used to treatment be used as sy Will the treatment be used in refit. If yes, is the disease 1 of the a. Philadelphia chromos b. Philadelphia chromos b. Philadelphia chromos 1. If Ph+, has the me Yes No 2. If Ph+, is disease refor Asparlas® (calaspargase pethe member cannot use Oncaspanodal NK/T-Cell Lymphoma Does member have nasal diseating it is given by the second of the seco	rst line therapy? Yes Noeat a member with a hypersens wastemic central nervous system lapsed/refractory disease? Yes_ne following: ome negative (Ph-)? Yes No_ent be used in conjunction with a coar® (pegaspargase):  se? Yes No_enduction therapy? Yes No_enduction the Yes No_enduction therapy? Yes No_enduction therapy? Yes No_enduction the Yes No_enduction the Yes No_enduction the Yes No_enduction the Yes No_enducti	NoNoNoNoNoNoNoNo
or Continued Authorization:  Date of last dose:  Does member have any evidence of progressive disease while on Asparlas® or Oncaspar®? Yes No  Has the member experienced adverse drug reactions related to Asparlas® or Oncaspar® therapy? Yes No	B.	response or no response to For Asparlas <sup>®</sup> (calaspargase pe	o induction therapy? Yes Negol-mknl), please provide a par	No
Date of last dose:	☐ If an	swer is none of the above, ple	ease indicate diagnosis:	
yes, please specify adverse reactions:	. Date of las . Does mem . Has the mo	t dose: ber have any evidence of progr	essive disease while on Asparl g reactions related to Asparlas	as <sup>®</sup> or Oncaspar <sup>®</sup> ? Yes No <sup>®</sup> or Oncaspar <sup>®</sup> therapy? Yes No
Prescriber Signature: Date: certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.	rescriber Si	gnature:	Date:	

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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