State of Oklahoma
SoonerCare
Inqovi® (Decitabine/Cedazuridine)
Prior Authorization Form

OKLAHOMA Health Care Authority | SoonerSelect | aetna

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

Pharmacy billing (NDC:_____**)** ***Start Date (or date of next dose):***_____

Dose:_____ ***Regimen:***_____

Billing Provider 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:

☐ **Myelodysplastic Syndrome (MDS)**

A. If MDS, please select the appropriate International Prognostic Scoring System (IPPS) group for the member's disease:

☐ Intermediate-1 ☐ Intermediate-2

☐ High-risk ☐ Other:_____

B. Has the member been previously treated for MDS? Yes☐ No☐

C. Please indicate the member's type of MDS:

☐ de novo MDS ☐ Secondary MDS

☐ Other:_____

D. Please indicate the member's French-American-British (FAB) MDS subtype:

☐ Refractory anemia ☐ Refractory anemia with ring sideroblasts

☐ Refractory anemia with excess blasts ☐ Chronic myelomonocytic leukemia (CMML)

☐ Other:_____

☐ **If answer is none of the 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 decitabine/cedazuridine? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to decitabine/cedazuridine 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.**