State of Oklahoma
SoonerCare
Lumoxiti® (Moxetumomab Pasudotox-tdfk)
Prior Authorization Form

OKLAHOMA Health Care Authority | SoonerSelect | aetna

***Member Name:*____________________ *Date of Birth:*___________ *Member ID#:*_______________**

Drug Information

***Physician billing (HCPCS code:*____________) Start Date *(or date of next dose):*_______________**

***Dose:*______________________________ *Regimen:*__________________________________**

Billing Provider Information

***Provider NPI:*________________________ *Provider Name:*______________________________**

***Provider Phone:*________________________ *Provider Fax:*______________________________**

Prescriber Information

***Prescriber NPI:*__________________ *Prescriber Name:*___________________________________**

***Prescriber Phone:*_____________ *Prescriber Fax:*________________ *Specialty:*________________**

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:

- ❑ **Hairy Cell Leukemia (HCL)**
  - A. Is HCL relapsed or refractory? Yes☐ No☐
  - B. Has the member received at least 2 prior systemic therapies, including treatment with a purine nucleoside analog (PNA)? Yes☐ No☐
  - C. Please provide member's creatinine clearance: ____________ mL/minute/1.73m^2
  - D. Will moxetumomab pasudotox-tdfk be used as a single-agent?
- ❑ **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 moxetumomab pasudotox-tdfk? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to moxetumomab pasudotox-tdfk 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.**	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*