

State of Oklahoma
Oklahoma Health Care Authority
Blincyto® (Blinatumomab) Prior Authorization Form

SoonerSelect



Member Name: Lucas Little Date of Birth: 07/30/2017 Member ID#: 345987

Drug Information

☒ Physician billing (HCPSC code: 12345) ☐ Pharmacy billing (NDC:)
Start Date (or date of next dose): 11/1/2024 Dose: 28mcg/day Regimen: Induction

Billing Provider Information

Provider NPI: 5467892394 Provider Name: Dr. Oncoso
Provider Phone: 555-324-7878 Provider Fax: 555-324-7877

Prescriber Information

Prescriber NPI: 5467892394 Prescriber Name: Dr. Oncoso
Prescriber Phone: 555-324-7878 Prescriber Fax: 555-324-7877 Specialty: Pediatric Oncology

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

- Will blinatumomab be used as a single-agent? Yes ☐ No ☒
- Please indicate the diagnosis and information:
 - ☒ Acute Lymphoblastic Leukemia (ALL)
 - A. What is the Philadelphia chromosome status of the leukemia?
 - ☐ Philadelphia chromosome negative (Ph-) ALL
 - ☒ Philadelphia chromosome positive (Ph+) ALL
 - ☐ Unknown
 - B. Does the patient have relapsed or refractory disease? Yes ☒ No ☐
 - C. Has member previously failed two Tyrosine Kinase Inhibitors (TKIs)? Yes ☐ No ☒
 - i. If yes, please list previously failed TKIs: Failed Imatinib
 - D. Will blinatumomab be used as consolidation in patient without substantial comorbidity with persistent or late clearance minimal residual disease positive (MRD+) following a complete response to induction? Yes ☐ No ☒
 - ☐ If answer is none of the above, please indicate diagnosis:

Additional Information: Patient with MDR+, failed Imatinib

For Continued Authorization:

- Date of last dose:
- Does member have any evidence of progressive disease while on blinatumomab? Yes ☐ No ☐
- Has the member experienced adverse drug reactions related to blinatumomab therapy? Yes ☐ No ☐
If yes, please specify adverse reactions:

Additional Information:

Prescriber Signature:  Date: 10/31/24

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.

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