OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY/MEDICAL PRIOR AUTHORIZATION/ REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-844-348-3720**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process.**

Drug Requested: Besponsa® (inotuzumab ozogamicin) **IV (J9999/C9028) (Medical)**

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength/Month: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

CLINICAL CRITERIA: Check **ALL** items below for appropriate diagnosis. Authorization process will be delayed if boxes for diagnosis are **NOT** checked.

- ❑ Patient is age 18 years or older

AND

- ❑ Patient has a diagnosis of B-cell precursor acute lymphoblastic leukemia (ALL)

AND

- **Select one of the conditions that corresponds to the patient:**
  - ❑ Patient shown to be Philadelphia Chromosome-positive, and is either relapsed OR refractory CD22 as defined in either condition below
    a. Patient has undergone treatment with at least one tyrosine kinase inhibitor {Imatinib (Gleevec®), Dasatinib (Sprycel®), Nilotinib (Tasigna®), Bosutinib (Bosulif®), Ponatinib (Iclusig®)}
    b. Patient has undergone 1 or 2 induction chemotherapy regimens for ALL

OR

  - ❑ Patient shown to be Philadelphia Chromosome-negative and:
    a. Patient has undergone 1 or 2 induction chemotherapy regimens for ALL

AND

Select below the therapy regimen/cycle phase for approval:

- ❑ **Cycle 1: 21 DAYS**

DAY 1 - 0.8 mg/m^2	**DAY 8** - 0.5 mg/m^2	**DAY 15** - 0.5 mg/m^2

total dose/cycle 1: 1.8 mg/m^2

- ❖ treatment cycle may be extended to 4 weeks if complete remission (CR) is achieved, or CR with incomplete hematologic recovery (CRi) and/or to allow for recovery from toxicity.

(continued on next page)

Subsequent cycles:

- ❑ Patients who achieve CR or CRi: 28 DAYS

DAY 1 - 0.5 mg/m^2	**DAY 8** - 0.5 mg/m^2	**DAY 15** - 0.5 mg/m^2

total dose/cycle: 1.5 mg/m^2

- ❑ Patients who do NOT achieve CR or CRi: 28 DAYS

DAY 1 - 0.8 mg/m^2	**DAY 8** - 0.5 mg/m^2	**DAY 15** - 0.5 mg/m^2

total dose/cycle 1: 1.8 mg/m^2

- ❖ if CR or CRi is not achieved within 3 cycles, discontinue treatment.

Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy - PropriumRx**

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by the Pharmacy and Therapeutic Committee**: 2/15/2018
UPDATED/REVISED: ~~6/19/2018; 8/16/2018;~~ **10/8/2018**