

**Omisirge® (Omidubicel-only) Prior Authorization Form**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Drug Information**

Physician billing (HCPCS code: \_\_\_\_\_) Start Date (or date of next dose): \_\_\_\_\_

Dose: \_\_\_\_\_ Dosing 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:

☐ **Hematological Malignancy** (Please specify: \_\_\_\_\_)

A. Is an allogeneic stem cell transplant using an umbilical cord blood donor source planned?

Yes \_\_\_\_ No \_\_\_\_

i. If yes, documentation of the donor source must be provided: \_\_\_\_\_

B. Will a myeloablative conditioning regimen be used? Yes \_\_\_\_ No \_\_\_\_

i. If yes, documentation of the member's conditioning regimen must be provided: \_\_\_\_\_

C. Will omidubicel-only be used to reduce time to neutrophil recovery and incidence of infection? Yes \_\_\_\_ No \_\_\_\_

☐ **If diagnosis is not listed above, please indicate diagnosis:** \_\_\_\_\_

Additional Information: \_\_\_\_\_

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. Failure to complete this form in full will result in processing delays.**PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization UnitFax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4CONFIDENTIALITY NOTICE

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