

State of Oklahoma
SoonerCare
Copiktra[®] (Duvelisib) Prior Authorization Form

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

Drug Information

Pharmacy billing (NDC: _____) 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:

Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)

A. Will duvelisib be used for relapsed or refractory disease? Yes ___ No ___

B. Will duvelisib be used as a single agent? Yes ___ No ___

C. Will duvelisib be used for disease progression following two or more lines of systemic therapy? Yes ___ No ___

If diagnosis is not listed 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 duvelisib? Yes ___ No ___

3. Has the member experienced adverse drug reactions related to duvelisib 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. 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 Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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