OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Tibsovo® (Ivosidenib) Prior Authorization Form

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

Drug Information

Pharmacy Billing (NDC: _____***) Start Date (or date of next dose):*** _____

Dose: _____ ***Regimen:*** _____

Pharmacy Information

Pharmacy NPI: _____ ***Pharmacy Name:*** _____

Pharmacy Phone: _____ ***Pharmacy Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:

☐ **Acute Myeloid Leukemia (AML)**
- A. Is AML newly-diagnosed? Yes☐ No☐
  - i. If member is younger than 75 years of age, are they unable to tolerate intensive induction chemotherapy? Yes☐ No☐
  - ii. Has an IDH1 mutation been detected? Yes☐ No☐
  - iii. Will Tibsovo® (ivosidenib) be used as a single-agent or in combination with azacitidine? Yes☐ No☐
- B. Is AML relapsed or refractory? Yes☐ No☐
  - i. Will Tibsovo® (ivosidenib) be used as a single-agent? Yes☐ No☐
  - ii. Has an IDH1 mutation been detected? Yes☐ No☐

☐ **Cholangiocarcinoma**
- A. Is diagnosis locally advanced or metastatic cholangiocarcinoma? Yes☐ No☐
- B. Has an IDH1 mutation been detected? Yes☐ No☐
- C. Has the member received prior treatment for this diagnosis? Yes☐ No☐

☐ **Myelodysplastic Syndromes (MDS)**
- A. Is diagnosis relapsed or refractory MDS? Yes☐ No☐
- B. Is there presence of isocitrate dehydrogenase-1 (IDH1) mutation, as detected by an FDA-approved test? Yes☐ No☐

☐ **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 ivosidenib? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to ivosidenib 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

CONFIDENTIALITY NOTICE