

**Zusduri™ (mitomycin intravesical solution) Prior Authorization Form**

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

**Drug Information**

Physician Billing (HCPCS code: \_\_\_\_\_) 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:**

**Non-Muscle Invasive Bladder Cancer (NMIBC)**

A. Is disease low-grade, intermediate-risk? Yes \_\_\_ No \_\_\_

B. Is disease recurrent? Yes \_\_\_ No \_\_\_

C. Will Zusduri™ be administered by intravesical instillation? Yes \_\_\_ No \_\_\_

**Other:** \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**For Continued Authorization:**

1. Please include the most recent office visit note or clinical summary from the hospital to support your request.

Is this information attached? Yes \_\_\_ No \_\_\_

2. Zusduri™ is only FDA approved for a total of 6 weekly instillations. Please provide a patient-specific, clinically significant reason for additional treatment(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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.***

*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.*

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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