

Modeyso™ (dordaviprone) Prior Authorization Form

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

Drug Information

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

Dose: _____ **Dosing 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:

Glioma

A. Is diagnosis diffuse midline glioma? Yes ___ No ___

B. Is there presence of H3 K27M mutation? Yes ___ No ___

C. Has member progressed on at least 1 prior therapy? Yes ___ No ___

D. Member's weight: _____ kg; Date taken: _____

Other: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does the member have any evidence of progressive disease while on dordaviprone?

Yes ___ No ___

3. Has the member experienced any adverse drug reactions related to dordaviprone therapy?

Yes ___ No ___

If yes, please specify adverse reactions: _____

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 Unit

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

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