

Inlexzo™ (gemcitabine intravesical system) 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:** (initial approvals will be for 6 months for 8 doses administered every 3 weeks)**1. Please indicate the diagnosis and information** **Non-Muscle Invasive Bladder Cancer (NMIBC)**

- Is diagnosis NMIBC with carcinoma in situ (CIS), with or without papillary tumors? Yes ___ No ___
- Is disease unresponsive to Bacillus Calmette-Guérin (BCG) treatment? Yes ___ No ___
- Will Inlexzo™ be used for intravesical administration only? Yes ___ No ___

 Other: _____**Additional Information:** _____

_____**For Continued Authorization:** (subsequent approvals will be for 6 months for 2 doses administered every 12 weeks)

- Date of last dose: _____
- Does member have any evidence of progressive disease while on Inlexzo™? Yes ___ No ___
- Has the member experienced adverse drug reactions related to Inlexzo™ 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.** 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 UnitFax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4CONFIDENTIALITY NOTICE

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