

**Omisirge® (omidubicel-only) Prior Authorization Form**

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

**Drug Information**

**Physician billing (HCPCS code:** \_\_\_\_\_ **) Start Date (or date of next dose):** \_\_\_\_\_

**Dose:** \_\_\_\_\_ **Dosing 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. Will omidubicel-only be used to reduce time to neutrophil recovery and incidence of infection? Yes \_\_\_ No \_\_\_

2. Please indicate the diagnosis and information:

**Hematological Malignancy** (Please specify: \_\_\_\_\_)

A. Is an allogeneic stem cell transplant using an umbilical cord blood donor source planned?

Yes \_\_\_ No \_\_\_

i. If yes, documentation of the donor source must be provided: \_\_\_\_\_

B. Will a myeloablative conditioning regimen be used? Yes \_\_\_ No \_\_\_

i. If yes, documentation of the member's conditioning regimen must be provided: \_\_\_\_\_

**Severe Aplastic Anemia**

A. Is an allogeneic stem cell transplant using an umbilical cord blood donor source planned?

Yes \_\_\_ No \_\_\_

i. If yes, documentation of the donor source must be provided: \_\_\_\_\_

ii. Is a compatible donor available? Yes \_\_\_ No \_\_\_

B. Will a reduced intensity conditioning regimen be used? Yes \_\_\_ No \_\_\_

i. If yes, documentation of the member's conditioning regimen must be provided: \_\_\_\_\_

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

**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.**

<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p>University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p>Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p><u>CONFIDENTIALITY NOTICE</u></p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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