OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Ninlaro® (ixazomib) 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:
   - ❑ **Multiple Myeloma**
     a. Is diagnosis symptomatic multiple myeloma? Yes____ No____
     b. Will ixazomib be used as primary therapy? Yes____ No____
     c. Will ixazomib be used following disease relapse after 6 months following primary induction therapy with the same regimen? Yes____ No____ *(if yes, select one of the following options if appropriate)*
        - ❑ Used in combination with lenalidomide and dexamethasone
        - ❑ Used in combination with cyclophosphamide and dexamethasone for a transplant candidate
        - ❑ Used in combination with pomalidomide and dexamethasone after failure with ≥2 prior therapies and disease progression within 60 days
     d. Will ixazomib be used as a single-agent for maintenance therapy following response to primary myeloma therapy in transplant candidates or following hematopoietic stem cell transplant? Yes____ No____
   - ❑ **Other:** ____________________________

Additional Information: ____

For Continued Authorization:

1. Date of last dose:____________________________
2. Does member have any evidence of progressive disease while on ixazomib? Yes____ No____
3. Has the member experienced adverse drug reactions related to ixazomib 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 do not send in chart notes. Specific information will be requested if necessary.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*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.*