OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

Poteligeo® (mogamulizumab-kpkc) 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:
   - ☐ **Primary Cutaneous Lymphomas – Mycosis Fungoides (MF)/Sézary Syndrome (SS)**
     - A. Will mogamulizumab be used as a single agent? Yes☐ No☐
     - B. Will mogamulizumab be used as primary treatment (does not include Stage 1A)? Yes☐ No☐
     - C. Is disease relapsed or refractory? Yes☐ No☐
   - ☐ **Adult T-Cell Leukemia/Lymphoma (ATLL)**
     - A. Will mogamulizumab be used as a single agent? Yes☐ No☐
     - B. Will mogamulizumab be used in combination with cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP)? Yes☐ No☐
       - i. Does member intend to proceed to transplant? Yes☐ No☐
     - C. Is disease relapsed or refractory? Yes☐ No☐
   - ☐ **If answer is none of the above, please indicate diagnosis:** _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____
2. Does patient have any evidence of progressive disease while on mogamulizumab therapy? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to mogamulizumab 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 Unit

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

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