OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Revuforj® (revumenib) 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:
   - ☐ Acute Myeloid Leukemia (AML)
   - ☐ Acute Lymphoblastic Leukemia (ALL)
   - ☐ Other: _____
2. Is disease relapsed or refractory? Yes☐ No☐
3. Is leukemia positive for a lysine methyltransferase 2A gene (KMT2A) translocation? Yes☐ No☐
4. Is there a susceptible nucleophosmin 1 (NPM1) mutation with no satisfactory alternative treatment option? Yes☐ No☐
5. Member's weight: _____kg; Date taken: _____
6. If member weighs <40kg, please provide the member' recent body surface area (BSA) in order to authorize the appropriate amount of drug: BSA: _____ ; Date obtained: _____

Additional Information: _____

_____

For Continued Authorization:

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