State of Oklahoma
SoonerCare
Inqovi® (decitabine/cedazuridine) 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:

☐ **Myelodysplastic Syndrome (MDS)**

a. Select the appropriate group for member's disease:
☐ Intermediate-1 ☐ Intermediate-2 ☐ High-risk ☐ Other: _____

b. Has the member been previously treated for MDS? Yes☐ No☐

c. Indicate the member's type of MDS:
☐ de novo MDS ☐ Secondary MDS ☐ Other: _____

d. Indicate the member's MDS subtype:
☐ Refractory anemia with ring sideroblasts ☐ Refractory anemia
☐ Refractory anemia with excess blasts ☐ Chronic myelomonocytic leukemia (CMML)
☐ Other: _____

☐ **Acute Myeloid Leukemia (AML)**

a. Will decitabine/cedazuridine be given in combination with venetoclax? Yes☐ No☐

b. Has member had prior systemic therapy? Yes☐ No☐

c. Is member eligible to receive intensive chemotherapy? Yes☐ No☐

☐ **Other:** _____

For Continued Authorization:

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

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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