OKLAHOMA Health Care Authority

# State of Oklahoma
## SoonerCare

# Zusduri™ (mitomycin intravesical solution) 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:**
   - ☐ **Non-Muscle Invasive Bladder Cancer (NMIBC)**
     - A. Is disease low-grade, intermediate-risk? Yes☐ No☐
     - B. Is disease recurrent? Yes☐ No☐
     - C. Will Zusduri™ be administered by intravesical instillation? Yes☐ No☐
   - ☐ **Other:** _____

**Additional Information:** _____

_____

_____

_____

**For Continued Authorization:**

1. Please include the most recent office visit note or clinical summary from the hospital to support your request. Is this information attached? Yes☐ No☐
2. Zusduri™ is only FDA approved for a total of 6 weekly instillations. Please provide a patient-specific, clinically significant reason for additional treatment(s): _____

_____

_____

**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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