OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Istodax® (romidepsin) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

☐***Physician billing (HCPCS code:_____)*** ☐***Pharmacy billing (NDC:_____)***

Dose:_____ Regimen:_____ Start Date (or date of next dose):_____

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 requested information:
   - A. Will romidepsin be used as a single-agent? Yes☐ No☐
   - B. Does member have relapsed or refractory disease? Yes☐ No☐
2. Please indicate the diagnosis and information:
   - ☐ **Primary Cutaneous Lymphomas – Mycosis Fungoides (MF)/Sézary Syndrome (SS)**
     - A. Will romidepsin be used as primary treatment? Yes☐ No☐
   - ☐ **Anaplastic Large Cell Lymphoma (ALCL), Primary Cutaneous**
     - A. Does member have multifocal lesions or regional nodes? Yes☐ No☐
     - B. Will romidepsin be used as primary treatment? Yes☐ No☐
   - ☐ **Peripheral T-Cell Lymphoma (PTCL)**
     - A. Will romidepsin be used as initial palliative intent? Yes☐ No☐
     - B. Will romidepsin be used as second-line and subsequent therapy in combination with duvelisib? Yes☐ No☐
   - ☐ **T-Cell Lymphoma, Extranodal NK/T-Cell Lymphoma, Nasal Type**
     - A. Does member have relapsed/refractory disease following additional therapy with an alternate combination chemotherapy regimen (asparaginase-based) not previously used? Yes☐ No☐
   - ☐ **If answer is none of the above, please indicate diagnosis:**_____

For Continued Authorization:

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

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *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.*