Tibsovo (ivosidenib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Acute myeloid leukemia(AML) ☐ Cholangiocarcinoma ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
Is drug going to be used in conjuction with a clinical trial? ☐ Yes ☐ No

Does patient have an IDH1 mutation? ☐ Yes ☐ No *Please submit docmentation of mutation.*
Does patient have an ECOG score 0 or 1? ☐ Yes ☐ No *Please submit docmentation.*
Does patient have an ECOG score 0 to 2? ☐ Yes ☐ No *Please submit docmentation.*
Does patient have an ECOG score 2 or greater? ☐ Yes ☐ No *Please submit docmentation.*
Has patient been previously treated with an IDH1 inhibitor such as but not limited to Idhifa(enasidenib)? ☐ Yes ☐ No *Please submit docmentation.*

<u>For Newly Diagnosis of Acute Myeloid Leukemia(AML), please aslo answer the following</u>:
Is patient 75 years of age or older? ☐ Yes ☐ No
Is patient 18 to 74 years of age inclusive? ☐ Yes ☐ No
If patient is 18 to 74 years of age, does the patient have at least one comorbid condition below that precludes use of intensive induction chemotherapy ? ☐ Yes ☐ No *Please submit docmentation.*
☐ Baseline ECOG ≥2
☐ Severe cardiac or pulmonary disease, such as congestive heart failure with an EF ≤50%, chronic stable angina, or FEV1 ≤65%
☐ Hepatic impairment with bilirubin >1.5 times the limit of normal
☐ Creatine Clearance <45mL/min

Has patient been previously treated with azacitidine or decitabine for myelodysplastic syndrome
Will Tibsovo(ivosidenib) be used as monotherapy? ☐ Yes ☐ No
Will Tibsovo(ivosidenib) be used in combination with azacitidine? ☐ Yes ☐ No

<u>For Relapsed or Refractory Acute Myeloid Leukemia(AML), please also answer the following</u>
Has the patient had at least one prior chemotherapy treatment? ☐ Yes ☐ No *Please submit documentation.*

Is patient ineligible for chemotherapy? ☐ Yes ☐ No *Documentation why patient is ineligible for chemotherapy is required.*

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For Diagnosis of Cholangiocarcinoma, please also answer the following:

Does the patient have nonresectable or metastatic cholangiocarcinoma? □ Yes □ No *Please submit documentation.*

Has the patient's disease progressed following at least 1 or 2 prior regimens? □ Yes □ No *Please submit documentation.*

Has the patient's disease progressed following on 3 or more regimens? □ Yes □ No *Please submit documentation.*

Was one of the prior regimens gemcitabine or 5-FU containing regimens? □ Yes □ No *Please submit documentation.*

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811