

## Idhifa (enasidenib) 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 NUM	ΛBER:				
FOLLOWING LINK: <u>HTTPS://MAGELLANRX.COM</u>	BER, YOU WILL NEED TO SUBMIT A PHI DISCLO	OSURE AUTHORIZATION FOR ON/DOC/EN-US/PHI DISCLO	M WITH THIS REQUEST WHICH CAN BE FOUND AT THE SURE 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 I	DISPENSING INFORMATION				
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILL	QUANTITY: S:		
■ NEW THERAPY	RENEWAL	IF RENEWAL: DA	E THERAPY INITIATED:		
DURATION OF THERAPY (SPECIFIC DATES):					
Continued on next page.					





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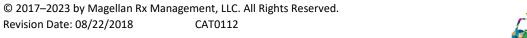
MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:		
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO	
MEDICATION/THERAPY (SPECIFY	<b>DURATION OF THERAPY</b> (SPECIFY	RESPONSE/REASON FOR	
DRUG NAME AND DOSAGE):	DATES):	FAILURE/ALLERGY:	
2. LIST DIAGNOSES:		ICD-10:	
□ Acute myeloid leukemia (AML)	1.7		
Other Diagnosis ICD-10 C	ode(s): : PLEASE PROVIDE ALL RELEVANT CLINIC	CAL INFORMATION TO SUPPORT A	
	PLEASE PROVIDE ALL RELEVANT CLINIC	AL INFORMATION TO SUPPORT A	
PRIOR AUTHORIZATION.  Clinical information:			
	cute myeloid leukemia (AML) with an is	cocitrata dabudraganaca 2 (IDU2)	
mutation?*   Yes   No	cute myelolu leukemia (AlviL) with an is	socitrate deliyarogenase-2 (IDH2)	
*Please submit documentation.			
rieuse subiiiit uotumentution.			
Has the natient had at least one previ	ous chemotherapy treatment?*   Yes	□ No	
*Please submit documentation.	bus chemotherapy treatment.	_ 110	
ricase sabilite accamentation.			
Is the patient ineligible for chemother	apv?* □ Yes □ No		
•	tient is ineligible for chemotherapy is re	equired for further review	
company pa		-quired yet yaranet resieus	
Are there any other comments, diagno	oses, symptoms, medications tried or fa	ailed, and/or any other information the	
physician feels is important to this rev		, , ,	
, , , , , , , , , , , , , , , , , , , ,			
Please note: Not all drugs/diagnosis ar	e covered on all plans. This request may	be denied unless all required	
information is received.	,		
	n provided is true and accurate to the be	est of my knowledge. I understand that	
	p or its designees may perform a routine		
	curacy of the information reported on th		
, , , , , , , , , , , , , , , , , , , ,	,		
Prescriber Signature or Electronic I.D.	Verification:	Date:	
CONFIDENTIALITY NOTICE: The documents according to the comments accord	ompanying this transmission contain confidential		
you are not the intended recipient, you are here	eby notified that any disclosure, copying, distribu	tion, or action taken in reliance on the contents	

**FAX THIS FORM TO: 800-424-7640** 

of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX)

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201

P.O. Box 64811 St. Paul, MN 55164-0811



and arrange for the return or destruction of these documents.

