

## Onureg (azacitidine) 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.

MEMBER INFORMATION			
LAST NAME:		FIRST NAME:	
PHONE NUMBER:		DATE OF BIRTH:	
STREET ADDRESS:			
CITY:		STATE: ZIP CO	DDE:
PATIENT INSURANCE ID	NUMBER:		
MAIF FEMALE I	HEIGHT (IN/CM): WI	FIGHT (LB/KG)· ALLE	-RGIFS:
		, i.e., (25) No.	
	RESCRIBER, YOU WILL NEED TO SUBMIT A PHI D  X.COM/MEMBER/EXTERNAL/COMMERCIAL/CO		
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ATIENT'S ALITHODIZED D	EDDESENITATIVE (IE ADDI ICAR	ı <b>c</b> \.	
ATIENT S AUTHORIZED R	REPRESENTATIVE (IF APPLICAB	LEJ:	
UTHORIZED REPRESENTA	ATIVE'S PHONE NUMBER:		
PRESCRIBER INFORMATI	ON		
LAST NAME:		FIRST NAME:	
LAST NAME:		FIRST NAME:	
		FIRST NAME:  EMAIL ADDRESS:	
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:	
PRESCRIBER SPECIALTY:			
PRESCRIBER SPECIALTY: NPI NUMBER:		EMAIL ADDRESS:	
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LAST NAME: PRESCRIBER SPECIALTY: NPI NUMBER: PHONE NUMBER: STREET ADDRESS: CITY: REQUESTOR (if different than p	rescriber):	EMAIL ADDRESS:  DEA NUMBER:  FAX NUMBER:  STATE: ZIP CO	
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PRESCRIBER SPECIALTY: NPI NUMBER: PHONE NUMBER: STREET ADDRESS: CITY: REQUESTOR (if different than p	FREQUENCY:	EMAIL ADDRESS:  DEA NUMBER:  FAX NUMBER:  STATE: ZIP CO  OFFICE CONTACT PERSO  LENGTH OF THERAPY/REFILLS:	QUANTITY:
PRESCRIBER SPECIALTY:  NPI NUMBER:  PHONE NUMBER:  STREET ADDRESS:  CITY:  REQUESTOR (if different than p	FREQUENCY:  RENEWAL	EMAIL ADDRESS:  DEA NUMBER:  FAX NUMBER:  STATE: ZIP CO  OFFICE CONTACT PERSO	QUANTITY:

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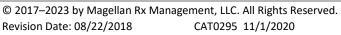


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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:	
1. HAS THE PATIENT TRIED ANY OTHER	MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
	10	
<b>3. REQUIRED CLINICAL INFORMATION:</b> PRIOR AUTHORIZATION.	PLEASE PROVIDE ALL RELEVANT CLINICA	AL INFORMATION TO SUPPORT A
Clinical Information: Is this drug being prescribed to this patterial?   Yes  No Does the patient have therapy-related	tient as part of a treatment regimen spo	ecified within a sponsored clinical
Does patient have proven CNS leukem	ia? □ Yes □ No	
Does the patient's acute myeloid leuke  ☐ Yes ☐ No	emia(AML) have inv(16), t(8;21), t(16;16	5), t(15;17), or t(9;22) translocations?
•	ent receive intensive induction chemot mission with incomplete blood count re	* *
Has patient achieved complete remissi following therapy with hypomethylatin	on(CR) or complete remission with incong agents? □ Yes □ No	omplete blood count recovery(CRi)
Is patient eligible for stem cell transpla	nnt? □ Yes □ No	
Has patient had a prior bone marrow o	or stem cell transplant?   Yes   No	
In the past 12 months, prior to starting malignancy? ☐ Yes ☐ No	g Onureg(azacitidine), has the patient b	een diagnosed with another
Are there any other comments, diagno physician feels is important to this revi	ses, symptoms, medications tried or fa iew?	iled, and/or any other information the
<b>Please note:</b> Not all drugs/diagnosis are information is received.	e covered on all plans. This request may	be denied unless all required



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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:		
<b>ATTESTATION:</b> 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:		
you are not the intended recipient, you are hereby notified that any	smission contain confidential health information that is legally privileged. If v disclosure, copying, distribution, or action taken in reliance on the contents information in error, please notify the sender immediately (via return FAX)		

**FAX THIS FORM TO: 800-424-7640** MAIL REQUESTS TO: Magellan Rx Management, LLC Attn: CP - 4201 P.O. Box 64811 St. Paul, MN 55164-0811

