

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 NUI	MBER:			
IF YOU ARE NOT THE PATIENT OR THE PRESCR FOLLOWING LINK: <u>HTTPS://MAGELLANRX.CO</u>	IBER, YOU WILL NEED TO SUBMIT A PHI DISC M/MEMBER/EXTERNAL/COMMERCIAL/COM	GHT (LB/KG): ALLERG LOSURE AUTHORIZATION FORM WITH THIS REQ MON/DOC/EN-US/PHI DISCLOSURE AUTHORIZ	UEST WHICH CAN BE FOUND AT THE ATION.PDF	
):		
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 DURATION OF THERAPY (SPE	RENEWAL ECIFIC DATES):	IF RENEWAL: DATE THERAPY	'INITIATED:	
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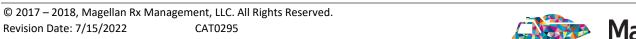


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MEMBER'S LAST NAME:	MEMBER'S FIRST	NAME:
1. HAS THE PATIENT TRIED ANY OTHE	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
☐ Acute myeloid leukemia(AML)		10.
□ Cholangiocarcinoma		
☐ Other diagnosis:ICD	-10	
3. REQUIRED CLINICAL INFORMATION	: PLEASE PROVIDE ALL RELEVANT CLINIC	AL 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 ECOG score 0 or Does patient have an ECOG score 0 to Does patient have an ECOG score 2 or Has patient been previously treated volume to the Please submit documentation.	P Yes No Please submit docmentart? Yes No Please submit docmentart? Yes No Please submit docmentart? Yes No Please submit docmentarter? Yes No Please submit and IDH1 inhibitor such as but not line	ntation. ntation. locmentation. nited to Idhifa(enasidenib)? Yes
	d Leukemia(AML), please aslo answer th	<u>e following:</u>
Is patient 75 years of age or older? Is patient 18 to 74 years of age inclusion		
	es the patient have at least one comorbion	d condition below that precludes use
	? □ Yes □ No Please submit docmenta	-
☐ Severe cardiac or pulmonary diseas	e, such as congestive heart failure with a	an EF <50%, chronic stable angina, or
FEV1 <65%	1. E times the limit of normal	
☐ Hepatic impairment with bilirubin > ☐ Creatine Clearance <45mL/min	1.5 times the limit of normal	
Has patient been previously treated v	with azacitidine or decitabine for myelod	lysplastic syndrome
Will Tibsovo(ivosidenib) be used as m	* *	
Will Tibsovo(ivosidenib) be used in co	ombination with azacitidine? Yes N	0
	eloid Leukemia(AML), please also answerchemotherapy treatment?	-
Is patient ineligible for chemotherapy required.	y? □ Yes □ No Documentation why pat	tient is ineligible for chemotherapy is





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For Diagnosis of Cholangiocarcinoma, please also answer the following:
Does the patient have nonresectable or metastatic cholangiocarcinoma? ☐ Yes ☐ No <i>Please submit documentation.</i>
Has the patient's disease progressed following at least 1 or 2 prior regimens? ☐ Yes ☐ No <i>Please submit documentation.</i>
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:
CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

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

