# Vanflyta (quizartinib)
# Prior Authorization Request Form

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

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

**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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| **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)<br>☐ Other diagnosis: _____ ICD-10 Code(s): | |

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

**Is patient going to be using drug in a clinical trial? ☐ Yes ☐ No**

Is the prescriber is an oncologist/hematologist? ☐ **Yes** ☐ **No**

Is the patient newly diagnosed acute myeloid leukemia (AML)? ☐ **Yes** ☐ **No Please provide documentation.**

Is the patient FLT3 internal tandem duplication (ITD)-positive? ☐ **Yes** ☐ **No Please provide documentation.**

Is the patient receiving standard "7+3" induction chemotherapy regimen of cytarabine 100 mg/m² per day (or 200 mg/m² per day) by continuous intravenous infusion and anthracycline (daunorubicin 60 mg/m² per day or idarubicin 12 mg/m² per day) by intravenous infusion? ☐ **Yes** ☐ **No Please provide documentation.**

Does patient have an Eastern Cooperative Oncology Group (ECOG) performance status 0-2? ☐ **Yes** ☐ **No**

Will VANFLYTA(quizartinib) be used as maintenance monotherapy following allogeneic hematopoietic stem cell transplantation (HSCT)? ☐ **Yes** ☐ **No**

Does patient have a diagnosis of AML secondary to prior chemotherapy or radiotherapy for other neoplasms? ☐ **Yes** ☐ **No**

Has patient been previously treated for AML? ☐ **Yes** ☐ **No Please provide documentation.**

Has patient been previously treated for AML with one of the following? ☐ **Yes** ☐ **No Please provide documentation.**
☐ Leukapheresis;
☐ Treatment for hyperleukocytosis with hydroxyurea
☐ Cranial radiotherapy for central nervous system (CNS) leukostasis
☐ Prophylactic intrathecal chemotherapy
☐Growth factor/cytokine support

Has patient had prior treatment with Vanflyta(quizartinib) or other FLT3-ITD inhibitors? ☐ **Yes** ☐ **No Please provide documentation.**

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**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
Phone: 877-228-7909