PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Idhifa® (enasidenib)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Idhifa 50 mg tablet ☐ Idhifa 100 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

For this drug to be covered, the patient must meet the following criteria (initial approval 6 months):

1. You must have a diagnosis of relapsed or refractory acute myeloid leukemia (AML) with an IDH2 (isocitrate dehydrogenase-2) mutation as detected by an FDA approved companion test (results must be faxed).
2. You must be over 18 years old.
3. You must have an Eastern Cooperative Oncology Group (ECOG) score between 0 and 2.

Continuation Criteria after initial 6 month approval that must be met:

1. Absence of unacceptable toxicity from the drug including differentiation syndrome and leukocytosis; AND
2. One of the following:
    a. Patient has achieved <5% of blasts in the bone marrow, no evidence of disease, and full recovery of peripheral blood counts (platelets >100,000/microliter and absolute neutrophil counts [ANC] >1,000/microliter); OR
    b. Patient has achieved <5% of blasts in the bone marrow, no evidence of disease, and partial recovery of peripheral blood counts (platelets >50,000/microliter and ANC >500/microliter); OR
    c. If patient was previous dependent on red blood cell and/or platelet transfusions and is now independent of both red blood cell and platelet transfusions; OR
    d. If patient was previous independent on red blood cell and platelet transfusions and remains independent of both red blood cell and platelet transfusions

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 03/2018

Last reviewed 09/2019

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Relapsed or refractory acute myeloid leukemia (AML)
- ☐ *Other – the patient's condition is:* _____

B. Does the patient have an IDH2 mutation as detected by FDA approved companion test? (please fax result)

- ☐ Yes
- ☐ No, *rationale*: _____

C. What previous treatments has the patient trialed for AML?

Drug	Dose	Dates	Outcome

Other: _____

Request to continue a previously authorized approval
Priority Health Precertification Documentation

A. Has the patient had unacceptable toxicity from the drug including differentiation syndrome or leukocytosis?

- ☐ Yes, *rationale for continuation*: _____
- ☐ No

B. Has the patient had a response to treatment (see page 1 of form)?

- ☐ Yes, *please describe*: _____
- ☐ No, *rationale for continuation:* _____

Additional information

Note: Quantity is limited to one tablet daily.

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