

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

Tibsovo[®] (ivosidenib)

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: ☐ Tibsovo 250 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Oral oncology partial fill program

Each fill of Tibsovo is limited to a 14-day supply at any network pharmacy. Patients are responsible for applicable deductible and copayments.

Precertification Requirements

Patient must have one of the following diagnoses and meet the corresponding criteria:

1. Relapsed or refractory acute myeloid leukemia (AML) with a susceptible IDH1 mutation as detected by an FDA-approved test or newly diagnosed AML with an IDH1 mutation in patients who are 75 years of age or older or who have comorbidities that preclude use of intensive induction chemotherapy
2. Must have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2

If approved, authorization for Tibsovo will be initially allowed for 6 months.

For continuation, patient must have met the following requirements:

1. The patient has not experienced disease progression
2. The patient is compliant in taking the medication as scheduled
3. The patient tolerated the medication

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.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Relapsed or refractory acute myeloid leukemia (AML) with a susceptible IDH1 mutation (documentation of the IDH-1 mutation must be submitted to Priority Health)
- ☐ Newly diagnosed AML with an IDH1 mutation in patients who are 75 years of age or older or who have comorbidities that preclude use of intensive induction chemotherapy
- ☐ *Other – the patient's condition is:* _____

B. What is the patient's ECOG performance status?

- ☐ 0: Fully active, able to carry on all pre-disease performance without restriction
- ☐ 1: Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature (e.g. light house work, office work)
- ☐ 2: Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours
- ☐ 3: Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
- ☐ 4: Completely disabled; cannot carry on any self-care; totally confined to bed or chair

**Request to continue a previously authorized approval
Priority Health Precertification Documentation**

A. Has the patient experienced disease progression?

- ☐ No
- ☐ Yes; *rationale for use:* _____

B. Is the patient compliant in taking the medications?

- ☐ Yes
- ☐ No; *rationale for use:* _____

C. Is the patient tolerating the medications?

- ☐ Yes
- ☐ No; *rationale for use:* _____