# 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
2. Must have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2

**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.

**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



**All fields must be complete and legible for review. Your office will receive a response via fax.** No changes made since 07/2018

Last reviewed 09/2018

## 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)
- ☐ *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:* _____



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Last reviewed 09/2018