State of Oklahoma
SoonerCare
Istodax® (Romidepsin) Prior Authorization Form

OKLAHOMA Health Care Authority | SoonerSelect | aetna

***Member Name:*______________________ *Date of Birth:*____________ *Member ID#:*_________________**

Drug Information

❑Physician billing (HCPCS code:____________) ❑Pharmacy billing (NDC:_______________________)

***Dose:*________________ *Regimen:*___________________ *Start Date (or date of next dose):*____________**

Billing Provider Information

***Provider NPI:*_________________________________ *Provider Name:*______________________________**

***Provider Phone:*___________________________ *Provider Fax:*___________________________________**

Prescriber Information

***Prescriber NPI:*___________________________ *Prescriber Name:*_________________________________**

***Prescriber Phone:*________________ *Prescriber Fax:*________________ *Specialty:*__________________**

Criteria

For Initial Authorization:

1. Please indicate the requested information:
   A. Will romidepsin be used as a single-agent? Yes____ No____
   B. Does member have relapsed or refractory disease? Yes____ No____
2. Please indicate the diagnosis and information:
   - ❑ **Primary Cutaneous Lymphomas – Mycosis Fungoides (MF)/Sézary Syndrome (SS)**
     A. Will romidepsin be used as primary treatment? Yes____ No____
   - ❑ **Anaplastic Large Cell Lymphoma (ALCL), Primary Cutaneous**
     A. Does member have multifocal lesions or regional nodes? Yes____ No____
     B. Will romidepsin be used as primary treatment? Yes____ No____
   - ❑ **Peripheral T-Cell Lymphoma (PTCL)**
   - ❑ **T-Cell Lymphoma, Extranodal NK/T-Cell Lymphoma, Nasal Type**
     A. Does member have relapsed/refractory disease following additional therapy with an alternate combination chemotherapy regimen not previously used? Yes____ No____
   - ❑ **If answer is none of the above, please indicate diagnosis:**_________________________________

Additional Information:____

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For Continued Authorization:

1. Date of last dose: ____
2. Does member have any evidence of progressive disease while on romidepsin? Yes____ No____
3. Has the member experienced any adverse drug reactions related to romidepsin therapy? Yes____ No____
   *If yes, please specify adverse reactions:*____

Prescriber Signature:________________________________ **Date:**____________________________

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

OHCA Approved – 05/27/2021