OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Adstiladrin® (Nadofaragene Firadenovec-vngc) Prior Authorization Form

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:*** _____

Name of outpatient health care facility where Adstiladrin® will be delivered to and administered at:

_____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

***For Initial Authorization:**

1. Please indicate the diagnosis and information:

☐ **Non-Muscle Invasive Bladder Cancer (NMIBC)**

A. Does member have a diagnosis of NMIBC with carcinoma in situ (CIS) with or without papillary tumors? Yes ☐ No ☐

B. Does member have high risk disease that was unresponsive to prior Bacillus Calmette-Guérin (BCG) therapy? Yes ☐ No ☐

☐ If answer is none of the above, please indicate diagnosis: _____

Additional Information: _____

_____

_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on nadofaragene firadenovec-vngc? Yes ☐ No ☐
3. Has member experienced adverse drug reactions related to nadofaragene firadenovec-vngc 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 and attach requested clinical notes will result in processing delays.*

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® 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.*