OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Erwinaze® (Asparaginase Erwinia Chrysanthemi) and Rylaze™ [Asparaginase Erwinia Chrysanthemi (Recombinant)-rywn] 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:***_____

Prescriber Information

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

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

Criteria

For Initial Authorization

1. **Please indicate the diagnosis and information:**
   - ☐ **Acute Lymphoblastic Leukemia**
     - A. Will Erwinaze® or Rylaze™ be used as a component of multi-agent chemotherapy? Yes☐ No☐
     - B. Does the member have a documented hypersensitivity to *Escherichia coli*-derived asparaginase? Yes☐ No☐
   - ☐ **Lymphoblastic Lymphoma**
     - A. Will Erwinaze® or Rylaze™ be used as a component of multi-agent chemotherapy? Yes☐ No☐
     - B. Does the member have a documented hypersensitivity to *Escherichia coli*-derived asparaginase? 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 Erwinaze® or Rylaze™? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to Erwinaze® or Rylaze™ 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. *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 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.**