OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Iwilfin™ (eflornithine) Prior Authorization Form

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

Pharmacy Billing (NDC:_____***) Start Date (or date of next dose):***_____

Dose:_____ ***Regimen:***_____

Pharmacy Information

Pharmacy NPI:_____ ***Pharmacy Name:***_____

Pharmacy Phone:_____ ***Pharmacy Fax:***_____

Prescriber Information

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

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

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:
   - ☐ **Neuroblastoma**
     - A. Is diagnosis high-risk neuroblastoma? Yes☐ No☐
     - B. Has member had at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy? Yes☐ No☐
     - C. Will eflornithine be used as a single agent to reduce the risk of relapse for a maximum of 2 years? Yes☐ No☐
     - D. Member's body surface area (BSA): _____ Date taken: _____
   - ☐ **Other** _____

Additional Information: _____

_____

DRAFT

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on eflornithine? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to eflornithine therapy? Yes☐ No☐

   *If yes, please specify adverse reactions:*_____

Additional Information:_____

_____

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 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.*