

**State of Oklahoma
SoonerCare
Voranigo® (vorasidenib) 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:

- ☐ **Astrocytoma**
☐ **Oligodendroglioma**
☐ **Other:** _____

2. Is diagnosis grade 2 astrocytoma or oligodendroglioma? Yes ___ No ___

3. Is there presence of susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation following surgery including biopsy, sub-total resection, or gross total resection? Yes ___ No ___

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on vorasidenib? Yes ___ No ___

3. Has the member experienced adverse drug reactions related to vorasidenib 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. 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. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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