OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Inlexzo™ (gemcitabine intravesical system) Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code:_____) Start Date (or date of next dose):_____

Dose:_____ Regimen:_____

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: *(initial approvals will be for 6 months for 8 doses administered every 3 weeks)*

1. Please indicate the diagnosis and information

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

a. Is diagnosis NMIBC with carcinoma in situ (CIS), with or without papillary tumors? Yes☐ No☐

b. Is disease unresponsive to Bacillus Calmette-Guérin (BCG) treatment? Yes☐ No☐

c. Will Inlexzo™ be used for intravesical administration only? Yes☐ No☐

☐ **Other:** _____

Additional Information: _____

_____

_____

_____

For Continued Authorization: *(subsequent approvals will be for 6 months for 2 doses administered every 12 weeks)*

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