

Revuforj® (revumenib) 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:

- Acute Myeloid Leukemia (AML)
 Acute Lymphoblastic Leukemia (ALL)
 Other: _____

2. Is disease relapsed or refractory? Yes No 3. Is leukemia positive for a lysine methyltransferase 2A gene (KMT2A) translocation? Yes No 4. Is there a susceptible nucleophosmin 1 (NPM1) mutation with no satisfactory alternative treatment option? Yes No

5. Member's weight: _____ kg; Date taken: _____

6. If member weighs <40kg, please provide the member's recent body surface area (BSA) in order to authorize the appropriate amount of drug: BSA: _____ ; Date obtained: _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on revumenib? Yes No 3. Has the member experienced adverse drug reactions related to revumenib 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.

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