OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Zusduri™ (mitomycin intravesical solution) 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:

1. **Please indicate the diagnosis and information:**
   - ☐ **Non-Muscle Invasive Bladder Cancer (NMIBC)**
     - A. Is disease low-grade, intermediate-risk? Yes☐ No☐
     - B. Is disease recurrent? Yes☐ No☐
     - C. Will Zusduri™ be administered by intravesical instillation? Yes☐ No☐
   - ☐ **Other:** _____

Additional Information: _____

_____

_____

_____

For Continued Authorization:

1. Please include the most recent office visit note or clinical summary from the hospital to support your request. Is this information attached? Yes☐ No☐
2. Zusduri™ is only FDA approved for a total of 6 weekly instillations. Please provide a patient-specific, clinically significant reason for additional treatment(s): _____

_____

_____

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.

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