

## State of Oklahoma Oklahoma Health Care Authority Ixempra® (Ixabepilone) Prior Authorization Form

Yes No If yes, please specify adverse reactions:	Member Name:	Date of Birth:	Member ID#:	
Billing Provider Information  SoonerCare Provider ID:		Drug Information		
Provider Information   Provider Name:   Provider Phone:   Provider Fax:   Prescriber Information   Prescriber Name:   Prescriber Information   Prescriber Name:   Prescriber Name:   Prescriber Phone:   Prescriber Fax:   Specialty:   Speci		☐ Physician billing (HCPCS code:	)	
SoonerCare Provider ID:	Dose:	Regimen:	Start Date:	
Provider Phone:		Billing Provider Inform	ation	
Prescriber NPI:	SoonerCare Provider ID:	Provider	Name:	
Prescriber NPI: Prescriber Name: Specialty:	Provider Phone:	Provider Fax:		
Criteria  For Initial Authorization (Initial approval will be for the duration of 6 months):  1. Diagnosis of metastatic or locally advanced breast cancer? Yes No  2. If answer is 'no' from previous question, please indicate diagnosis:  3. Please indicate the following regarding the usage of ixabepilone:  Yes No Using in combination with capecitabine after failure of an anthracycline a taxane?  Yes No Using as monotherapy after failure of an anthracycline, a taxane and capecitabine?  4. Please provide dates/dose/duration of previous treatment:  5. Please provide member's body surface area (m²):  Additional Information:  For Continued Authorization:  1. Does member have any evidence of progressive disease while on ixabepillone?  Yes No  2. Has the member experienced any adverse drug reactions related to ixabepilone therapy?  Yes No  If yes, please specify adverse reactions:  Additional Information:  Additional Information:	Prescriber Information			
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Prescriber Signature:  I certify that the indicated treatment is medically necessary and all information is true and correct to the best knowledge.  Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in	knowledge.			

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

will result in processing delays.

University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit

> Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4

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