



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Idhifa<sup>®</sup> Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<b>Select the diagnosis below:</b> <input type="checkbox"/> Acute myeloid leukemia (AML) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Clinical Information:</b> Does the patient have relapsed or refractory disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test (e.g., Abbott RealTime IDH2 assay) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Idhifa prescribed by or in consultation with a hematologist/oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Reauthorization:</b> Does the patient show evidence of disease progression while on Idhifa therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Quantity Limit Requests:</b> What is the quantity requested per DAY? _____ <b>What is the reason for exceeding the plan limitations?</b> <input type="checkbox"/> Titration or loading dose purposes <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> Other: _____					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.  
 For urgent or expedited requests please call 1-800-711-4555.  
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.