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

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

Istodax[®] Prior Authorization Request Form

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

Member Information (required)	Provider Information (required)
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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 (required)

Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)

Select the diagnosis below:

Cutaneous T-cell lymphoma (CTCL)

Peripheral T-cell lymphoma (PTCL)

Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Is Istodax prescribed by or in consultation with a hematologist/oncologist? Yes No

For cutaneous T-cell lymphoma (CTCL), answer the following:

Has the patient had trial and failure, contraindication, or intolerance to one systemic therapy for the treatment of CTCL [e.g., Trexall (methotrexate), Targretin (bexarotene), Cytosan (cyclophosphamide)]? Yes No

For peripheral T-cell lymphoma (PTCL), answer the following:

Has the patient had trial and failure, contraindication, or intolerance to one therapy for the treatment of PTCL [e.g., CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone), CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone), dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin), hyper CVAD (cyclophosphamide, vincristine, doxorubicin, dexamethasone) alternating with high-dose methotrexate and cytarabine]? Yes No

Reauthorization:

If this is a reauthorization request, answer the following question:

Does the patient show evidence of disease progression while on Istodax therapy? Yes No

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

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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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