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

Istodax® Prior Authorization Request Form

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ 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), Cytoxan (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.