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

Rydapt® 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:

- ❑ Acute myeloid leukemia (AML)
- ❑ Aggressive systemic mastocytosis (ASM)
- ❑ Mast cell leukemia (MCL)
- ❑ Systemic mastocytosis with associated hematological neoplasm (SM-AHN)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Is Rydapt prescribed by or in consultation with a hematologist or oncologist? ❑ **Yes** ❑ **No**

For acute myeloid leukemia (AML), answer the following:

Does the patient have newly diagnosed acute myeloid leukemia (AML)? ❑ **Yes** ❑ **No**

Does the patient have FMS-like tyrosine kinase 3 (FLT3) mutation-positive as detected by a U.S. Food and Drug Administration (FDA)-approved test? ❑ **Yes** ❑ **No**

Will Rydapt be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient show evidence of disease progression while on Rydapt (midostaurin) therapy? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ 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)
- ❑ Requested strength/dose is not commercially available
- ❑ 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?

_____

_____

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.

Office use only: Rydapt_Comm_2018Jun-W