

Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Ninlaro (Ixazomib Citrate) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

## **Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Ninlaro (Ixazomib Citrate).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: <u>1-866-331-2104</u>]. If you have any questions or concerns, please call <u>1-866-331-2103</u>. Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: <a href="http://pithelp.appl.kp.org/MAS/formulary.html">http://pithelp.appl.kp.org/MAS/formulary.html</a>

1 – Patient Information				
Patient Name:	Kaiser Medical ID#:	Date of Birth:		
2 – Provider Information				
Prescriber specialty: ☐ Hematologist ☐	Oncologist Other:			
If consulted with a specialist, specialist name and specialty:				
Provider Name:	Provider NPI:			
Provider Address:				
Provider Phone #:	Provider Fax #:	·		
Please check the boxes that apply: □Initial Request □ Continuation of Therapy Request				
3 – Pharmacy Information				
Pharmacy Name:	Pharmacy NPI:			
Pharmacy Phone #	Pharmacy Fax #:			
4 – Drug Therapy Requested				
Jig				
Drug 2: Name/Strength/Formulation:				
3.6.				

	5 – Di	agnosis
Please select Indication:		<del>3</del>
□ Multiple myeloma		
□ Other:		
	6–Clinica	al Criteria
Initial Therapy:		
1. Does the member	r have both of the following?	
a) □ No □ Y	es Diagnosis of multiple myeloma	
· ·	•	on, or intolerance to treatment with lenalidomide, bortezomik in 60 days of completion of the last therapy
Continuation of Therapy	:	
1. Member does No	OT show evidence of progressive dise	ase while on therapy: □ No □ Yes
	7 – Provid	er Sign-Off
Additional Information -	Please provide any additional infor	mation that should be taken into consideration.
I certify that the informa	tion provided is accurate. Supporting d	ocumentation is available for State audits.
Provider Signature:		Date:

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intended for receipt by your facility

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