



Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Joenja (leniolisib)**. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: [Pharmacy | Community Provider Portal | Kaiser Permanente](#)

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____
Prescriber Address: _____
Prescriber Phone #: _____ Prescriber Fax #: _____
Do you have an approved provider referral number from Kaiser Permanente?
 Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____
Pharmacy Phone # _____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____
Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
 Initial therapy Continuing therapy, state start date: _____
2. Indicate the patient’s diagnosis for the requested medication: _____

Clinical Criteria:

1. Is the prescriber an Immunologist or Allergist?
 No Yes
2. Is the patient 12 years of age or older?
 No Yes
3. Does the patient weigh ≥ 45 kg?
 No Yes
4. Does the patient have a documented diagnosis of activated PI3K δ syndrome (APDS; also known as PASLI disease)?
 No Yes
5. Are there documented nodal and/or extranodal lymphoproliferation, clinical findings/manifestations compatible with APDS (e.g., history of repeated oto-sino-pulmonary infections, and/or organ dysfunction), and present of at least 1 measurable nodal lesion on a CT or MRI scan?
 No Yes

Additional criteria for females of childbearing age (12 to 50 years):

6. Is there documentation of a negative pregnancy test within the past month?
 No Yes
7. Is the patient on at least one form of a highly effective method of contraception, which should be continued during treatment and for 1 week after the last dose?
 No Yes

For continuation of therapy, please respond to additional questions below:

1. Does the patient continue to meet initial review criteria?
 No Yes
2. Is there documented disease progression?
 No Yes
3. Is there documented reduction in the size of nodal lesions on CT or MRI scan?
 No Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:

Date:

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