

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.**

Section A – Member Information

| | | |
|--|------------|------------|
| First Name: | Last Name: | Member ID: |
| Address: | | |
| City: | State: | ZIP Code: |
| Phone: | DOB: | Allergies: |
| Primary Insurance Information (if any): | | |
| Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____ | | |
| Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____ | | |

Section B - Provider Information

| | | | |
|---|------------|-----------|------------|
| First Name: | Last Name: | M.D./D.O. | |
| Address: | City: | State: | ZIP code: |
| Phone: | Fax: | NPI #: | Specialty: |
| Office Contact Name / Fax attention to: | | | |

Section C - Medical Information

| | |
|---|--------------|
| Medication: | Strength: |
| Directions for use: | Quantity: |
| Diagnosis (Please be specific & provide as much information as possible): | ICD-10 CODE: |
| Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____ | |

Section D – Previous Medication Trials

| Medication Name | Strength | Directions | Dates of Therapy | Reason for failure / discontinuation |
|-----------------|----------|------------|------------------|--------------------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives**

| | | |
|---------------------------|--------------------------|--------------------|
| Member First name: | Member Last name: | Member DOB: |
|---------------------------|--------------------------|--------------------|

Clinical and Drug Specific Information
ALL REQUESTS

| | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does the patient have a diagnosis of acute myeloid leukemia (AML)? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is the AML IDH1 mutation-positive? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is the disease relapsed or refractory? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is the use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium? <i>If yes, list supported use:</i> |

CONTINUATION OF THERAPY

| | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does the patient show evidence of progressive disease while on Tibsovo therapy? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is there documentation of positive clinical response to Tibsovo therapy? <i>If yes, list positive clinical response:</i> |

Provider Signature: _____ **Date:** _____

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