Oncology Agents – Phosphatidylinositol 3-Kinase (PI3K) Inhibitors – Oral – Washington Prior Authorization Request Form

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.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID	
Pharmacy name	Pharmacy NPI	Telephone number	Pharmacy name
Prescriber	Prescriber NPI	Telephone number	Prescriber
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, is there documentation of a positive clinical response? ☐ Yes ☐ No

2. What is the patient's diagnosis?
   ☐ Breast cancer, advanced or metastatic hormone receptor-positive, HER2-negative, PIK3CA- mutated
   ☐ Chronic lymphoid leukemia
   ☐ Small lymphocytic lymphoma, relapsed or refractory
   ☐ Other Specify: _____

3. Provide the following for the patient:
   Indicate disease stage:
   Indicate disease type (i.e. New onset, refractory, etc.):

4. Indicate if prescribed by or in consultation with:
   ☐ Oncologist ☐ Hematologist ☐ Other Specify: _____

For diagnosis of Breast cancer, advanced or metastatic hormone receptor-positive, HER2-negative, PIK3CA- mutated:

5. Will the prescribed medication be used in combination with fulvestrant? ☐ Yes ☐ No

6. Provide documentation of all of the following:
   a. Hormone receptor-positive
   b. HER2-negative
   c. PIK3CA-mutated confirmed

7. Has cancer progressed while on or after receiving endocrine therapy (e.g. anastrozole, letrozole, exemestane, tamoxifen)? ☐ Yes ☐ No

For diagnosis of Chronic lymphoid leukemia:

8. For duvelisib:
   Has patient relapsed? ☐ Yes ☐ No

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Is disease refractory? ☐ Yes ☐ No

Does patient have a history of failure, contraindication, or intolerance to one of the following?

At least two prior chemotherapy regimen containing:

☐ Bruton tyrosine kinase inhibitor (BTKi)
☐ Beta cell lymphoma-2 inhibitor (BCL2i)
☐ Monoclonal antibody (e.g. obinutuzumab, rituximab)
☐ Other Specify: _____

9. For idelalisib:

Has patient relapsed? ☐ Yes ☐ No

Has the patient previously taken another PI3K inhibitor without evidence of progression? ☐ Yes ☐ No

Will the prescribed medication be used in combination with rituximab? ☐ Yes ☐ No

Does patient have a history of failure, contraindication, or intolerance to one of the following?

At least one prior chemotherapy regimen containing:

☐ Bruton tyrosine kinase inhibitor (BTKi)
☐ Beta cell lymphoma-2 inhibitor (BCL2i)
☐ Other Specify: _____

For diagnosis of Small lymphocytic lymphoma, relapsed or refractory:

10. Is this being used in combination with other chemotherapeutic, radiotherapeutic, or adjuvant agents?
☐ Yes ☐ No
If yes, list all therapies:

11. Does patient have a history of failure, contraindication, or intolerance to one of the following?

At least two prior chemotherapy regimen containing:

☐ Bruton tyrosine kinase inhibitor (BTKi)
☐ Beta cell lymphoma-2 inhibitor (BCL2i)
☐ Monoclonal antibody (e.g. obinutuzumab, rituximab)
☐ Other Specify: _____

12. Indicate for patient:

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Height (cm): **Date taken:** Weight (kg): **Date taken:** Body surface area (m^2): **Date taken:**		
Chart notes, labs and all diagnostic tests confirming diagnosis are required with this request		
Prescriber signature	Prescriber specialty	Date