Oncology Agents – Phosphatidylinositol 3-Kinase (PI3K) Inhibitors - Oral

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
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

   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:
Height (cm): **Date taken:**
Weight (kg): **Date taken:**
Body surface area (m^2): **Date taken:**

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)