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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Rydapt® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)
<p>Continuation of therapy:</p> <p>Is this a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: (REQUIRED)</p> <p>_____</p> <p>_____</p>

<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Acute myeloid leukemia (AML)</p> <p><input type="checkbox"/> Aggressive systemic mastocytosis (ASM)</p> <p><input type="checkbox"/> Mast cell leukemia (MCL)</p> <p><input type="checkbox"/> Systemic mastocytosis with associated hematological neoplasm (SM-AHN)</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>

<p>Clinical Information:</p> <p>Is there presence of contraindications or absolute drug interactions with existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>For acute myeloid leukemia (AML), also answer the following:</p> <p>Does the patient have newly diagnosed acute myeloid leukemia (AML)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have FLT3 mutation-positive disease as detected by a U.S. Food and Drug Administration (FDA)-approved test? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will Rydapt be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-297-2870.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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