Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Joenja (leniolisib) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 3 months; Continuation- 6 months

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 PI3Kδ 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 <u>additional questions</u> 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:**