

Krazati® (Adagrasib) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Pharmacy Billing (NDC: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

Billing Provider Information

Pharmacy NPI: _____ Pharmacy Name: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria**For Initial Authorization:****1. Please indicate the diagnosis and information:** **Non-Small Cell Lung Cancer (NSCLC)**A. Is diagnosis recurrent, advanced, or metastatic NSCLC? Yes No B. Is there the presence of KRAS G12C mutation in tumor or plasma specimen as determined by an FDA approved test? Yes No C. Has the member received at least 1 prior systemic therapy? Yes No D. Will adagrasib be used as a single agent? Yes No **Colorectal Cancer (CRC)**A. Is diagnosis locally advanced or metastatic CRC? Yes No B. Is there the presence of KRAS G12C mutation in tumor specimen as determined by an FDA approved test? Yes No C. Will adagrasib be used in combination with cetuximab? Yes No D. Has member received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy? Yes No **If diagnosis is not listed above, please indicate diagnosis:** _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does the member have any evidence of progressive disease while on adagrasib? Yes No 3. Has the member experienced adverse drug reactions related to adagrasib therapy? Yes No

If yes, please specify adverse reactions: _____

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.
All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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