OKLAHOMA Health Care Authority

# State of Oklahoma SoonerCare
# Loqtorzi™ (Toripalimab-tpzi) Prior Authorization Form

SoonerSelect | aetna

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

## Drug Information

☐ ***Physician billing*** **(HCPCS code:** _____**)** ☐ ***Pharmacy billing*** **(NDC:** _____**)**

***Dose:*** _____ ***Regimen:*** _____ ***Start Date (or date of next dose):*** _____

## Billing Provider Information

***Provider NPI:*** _____ ***Provider Name:*** _____

***Provider Phone:*** _____ ***Provider Fax:*** _____

## Prescriber Information

***Prescriber NPI:*** _____ ***Prescriber Name:*** _____

***Prescriber Phone:*** _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

## Criteria

***For Initial Authorization:**

1. Please indicate the diagnosis and information:
   - ☐ Nasopharyngeal Carcinoma (NPC)
   - ☐ Other: _____
2. Is disease metastatic or recurrent, locally advanced NPC? Yes☐ No☐
   a. Will toripalimab-tpzi be used in the first-line setting? Yes☐ No☐
   b. Will toripalimab-tpzi be used in combination with cisplatin and gemcitabine? Yes☐ No☐
3. Is disease previously treated recurrent unresectable or metastatic NPC? Yes☐ No☐
   a. Has disease progressed on or following a platinum-containing chemotherapy? Yes☐ No☐
   b. Will toripalimab-tpzi be used as a single agent? Yes☐ No☐
   c. Please provide member's weight (kg): _____

Additional Information: _____

_____

_____

**For Continued Authorization:**

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on toripalimab-tpzi? Yes☐ No☐
3. Has member experienced adverse drug reactions related to toripalimab-tpzi 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.*** *Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full and attach requested clinical notes will result in processing delays.*

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| Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® 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. |  |