

Loqtorzi™ (Toripalimab-tpzi) Prior Authorization Form

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.

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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