

State of Oklahoma





SoonerCare

Lumakras™	(Sotorasib)	Prior	Authorization	Form
Lumarias	OULUIASIN		AutionZation	

Member Name:	Date of Birth:	Member ID#:				
Drug Information						
Pharmacy billing (NDC:) Start Date (or date of next dose):					
Dose:	Dosing 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 disease locally advanced or metastatic? Yes____ No____
 - B. Is there presence of KRAS G12C mutation? Yes No
 - C. Has disease progressed on at least 1 prior systemic therapy ? Yes____ No____
 - D. Will Lumakras[™] be used as a single agent? 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 sotorasib? Yes No

3. Has the member experienced any adverse drug reactions related to sotorasib therapy?

Yes___No___

If yes, please specify adverse reactions:_____

Additional Information:

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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