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# State of Oklahoma
# SoonerCare
# Tagrisso® (Osimertinib) Prior Authorization Form

***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

***Provider NPI:_____________________________ Provider Name:____________________________________***

***Provider Phone:___________________________ Provider Fax:_____________________________________***

## Prescriber Information

***Prescriber NPI:______________________ Prescriber Name:_______________________________________***

***Prescriber Phone:_______________ Prescriber Fax:_______________ Specialty:_____________________***

## Criteria

**For Initial Authorization (Initial approval will be for the duration of 6 months):**

1. Please indicate diagnosis and information:
   - ❑ **Non-Small Cell Lung Cancer (NSCLC)**
     - A. Is diagnosis non-metastatic NSCLC? Yes____ No____
       - i. Will osimertinib be used as adjuvant therapy following tumor resection? Yes____ No____
       - ii. Is disease epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R mutation positive? Yes____ No____
     - B. Is diagnosis metastatic NSCLC? Yes____ No____
       - i. Is disease EGFR T790M mutation-positive? Yes___ No___
       - ii. Is disease EGFR exon 19 deletion or exon 21 L858R mutation positive? Yes____ No____
     - C. Will osimertinib be used as a single agent? Yes____ No____
   - ❑ **If diagnosis is not listed above, please provide diagnosis:_____________________________**

Additional Information:__________________________________________________________________________

_______________________________________________________________________________________________

**For Continued Authorization:**

1. Date of last dose:_____________________
2. Does member have any evidence of progressive disease while on osimertinib? Yes____ No____
3. Has the member experienced adverse drug reactions related to osimertinib 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**. | CONFIDENTIALITY NOTICE<br>*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.* |
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