OKLAHOMA Health Care Authority

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State of Oklahoma
SoonerCare

Tazverik® (tazemetostat) Prior Authorization Form

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

Drug Information

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

Dose:_____ Regimen:_____

Pharmacy 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:
   - ☐ **Epithelioid Sarcoma**
     - A. Is disease metastatic or locally advanced? Yes☐ No☐
     - B. Is member eligible for complete resection? Yes☐ No☐
   - ☐ **Follicular Lymphoma (FL)**
     - A. Is disease relapsed or refractory? Yes☐ No☐
     - B. Used as subsequent therapy and EZH2 mutation positive after 2 or more prior systemic therapies? Yes☐ No☐
     - C. Used as second line therapy irrespective of EZH2 mutation status for older or infirm members with indications for treatment where other options are not expected to be tolerable? Yes☐ No☐
     - D. Used as third line and/or subsequent therapy (and not previously given) irrespective of EZH2 mutation status in members with indications for treatment? Yes☐ No☐
   - ☐ **Other:** _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on tazemetostat? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to tazemetostat? 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 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.	