

State of Oklahoma





SoonerCare

Zynyz<sup>™</sup> (Retifanlimab-dlwr) Prior Authorization Form

Member Name:	Date of Birth:	Member ID#:
Drug Information		
Physician billing (HCPCS code:	) 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:		
1. Please indicate the diagnosis and information:		
Merkel Cell Carcinoma (MCC)		

A. Is the diagnosis metastatic or recurrent locally advanced MCC? Yes No

If diagnosis is not listed above, please indicate diagnosis:

Additional Information:

## For Continued Authorization:

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

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