OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Imjudo® (Tremelimumab-actl) Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code: _____***)*** ***Start Date (or date of next dose):*** _____

Dose: _____ ***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:
   - ☐ **Non-Small Cell Lung Cancer (NSCLC)**
     - A. Does the member have metastatic disease? Yes ☐ No ☐
     - B. Is there an epidermal growth factor receptor (EGFR), anaplastic lymphoma kinase (ALK), or ROS1 mutations? Yes ☐ No ☐
     - C. Will tremelimumab-actl be given in combination with durvalumab and platinum-based chemotherapy? Yes ☐ No ☐
   - ☐ **Hepatocellular Carcinoma (HCC)**
     - A. Is the diagnosis unresectable HCC? Yes ☐ No ☐
     - B. Will tremelimumab-actl be given in conjunction with durvalumab? 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 tremelimumab-actl therapy? Yes ☐ No ☐
3. Has the member experienced any adverse drug reactions related to tremelimumab-actl therapy? Yes ☐ No ☐
   - A. 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. Please do not send in chart notes. Specific information will be requested if necessary.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:
University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4