OKLAHOMA
Health Care Authority

# 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:*** _____

## 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 (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. Is diagnosis locally advanced or metastatic non-squamous NSCLC? Yes ☐ No ☐
       - i. Will osimertinib be used as first-line treatment? Yes ☐ No ☐
       - ii. Is disease EGFR exon 19 deletion or exon 21 L858R mutation positive? Yes ☐ No ☐
       - iii. Will osimertinib be used in combination with pemetrexed and platinum-based (cisplatin or carboplatin) chemotherapy? Yes ☐ No ☐
     - D. 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.*



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