

**Lumakras™ (sotorasib) 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:**

**1. Please indicate the diagnosis and information:**

**Non-Small Cell Lung Cancer (NSCLC)**

- a. Is disease locally advanced or metastatic NSCLC? Yes \_\_\_ No \_\_\_
- b. Is there presence of KRAS G12C mutation? Yes \_\_\_ No \_\_\_
- c. Has disease progressed on at least 1 prior systemic therapy? Yes \_\_\_ No \_\_\_
- d. Will sotorasib be used as a single agent? Yes \_\_\_ No \_\_\_

**Colorectal Cancer (CRC)**

- a. Is disease metastatic CRC? Yes \_\_\_ No \_\_\_
- b. Is there presence of KRAS G12C mutation? Yes \_\_\_ No \_\_\_
- c. Has member received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy? Yes \_\_\_ No \_\_\_
- d. Will sotorasib be used in combination with cetuximab or panitumumab? Yes \_\_\_ No \_\_\_
  - i. If sotorasib is being used as a single agent, is the member unable to tolerate epidermal growth factor receptor (EGFR) inhibitor due to toxicity? Yes \_\_\_ No \_\_\_

**Other:** \_\_\_\_\_

**Additional Information:** \_\_\_\_\_

**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_

2. Does the member have any evidence of progressive disease while on sotorasib? Yes \_\_\_ No \_\_\_

3. Has the member experienced any adverse drug reactions related to sotorasib 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.**

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

CONFIDENTIALITY NOTICE

*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.*