

Krazati® (adagrasib) Prior Authorization Form

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

Drug Information

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

Dose: _____ Regimen: _____

Billing Provider 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)**

- Is diagnosis recurrent, advanced, or metastatic NSCLC? Yes ___ No ___
- Is there the presence of KRAS G12C mutation in tumor or plasma specimen as determined by an FDA approved test? Yes ___ No ___
- Has the member received at least 1 prior systemic therapy? Yes ___ No ___
- Will adagrasib be used as a single agent? Yes ___ No ___

 Colorectal Cancer (CRC)

- Is diagnosis locally advanced or metastatic CRC? Yes ___ No ___
- Is there the presence of KRAS G12C mutation? Yes ___ No ___
- Has member received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy? Yes ___ No ___
- Will adagrasib be used in combination with cetuximab or panitumumab? Yes ___ No ___
 - If adagrasib is being used as a single agent, is the member unable to tolerate epidermal growth factor receptor (EGFR) inhibitor due to toxicity? Yes ___ No ___

 If diagnosis is not listed above, please indicate diagnosis: _____

Additional Information: _____

For Continued Authorization:

- Date of last dose: _____
- Does the member have any evidence of progressive disease while on adagrasib? Yes ___ No ___
- Has the member experienced adverse drug reactions related to adagrasib 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 UnitFax: 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.