

Augtyro™ (repotrectinib) Prior Authorization Form

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

Drug Information

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

Dose: _____ 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 diagnosis and information:

Non-Small Cell Lung Cancer (NSCLC)

A. Is NSCLC locally advanced or metastatic? Yes ___ No ___

B. Is NSCLC ROS1-positive? Yes ___ No ___

C. Will repotrectinib be used as a single agent? Yes ___ No ___

Solid Tumor

A. Does tumor have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion? Yes ___ No ___

B. Is tumor locally advanced or metastatic or surgical resection is likely to result in severe morbidity?
Yes ___ No ___

C. Has tumor progressed following treatment or there is no satisfactory alternative therapy?
Yes ___ No ___

D. Will repotrectinib be used as a single agent? Yes ___ No ___

Other: _____

Additional information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on repotrectinib? Yes ___ No ___

3. Has member experienced adverse drug reactions related to repotrectinib 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.

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

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