

**Emrelis™ (telisotuzumab vedotin-tllv) Prior Authorization Form**

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

**Drug Information**

**Physician billing (HCPCS code:** \_\_\_\_\_ **)**  **Pharmacy billing (NDC:** \_\_\_\_\_ **)**

**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 provide member's diagnosis:

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

- A. Is diagnosis recurrent, advanced, or metastatic non-squamous NSCLC? Yes\_\_\_\_ No\_\_\_\_
- B. Does member have disease with high c-Met/MET protein overexpression, defined as  $\geq 50\%$  of tumor cells with strong staining [immunohistochemistry (IHC) 3+]? Yes\_\_\_\_ No\_\_\_\_
- C. Epidermal growth factor receptor (EGFR) wild-type? Yes\_\_\_\_ No\_\_\_\_
- D. Has member received prior systemic therapy? Yes\_\_\_\_ No\_\_\_\_
- E. Member's ECOG performance status: \_\_\_\_\_
- F. Will Emrelis™ be used as a single agent? Yes\_\_\_\_ No\_\_\_\_
- G. Member's weight: \_\_\_\_\_ (kg)

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

**For Continued Authorization:**

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

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

3. Has the member experienced any adverse drug reactions related to Emrelis™ 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. Please do not send in chart notes. Specific information will be requested if necessary. 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

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