

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. Will osimertinib be used as a single agent? Yes ___ No ___
2. Is disease epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R mutation-positive? Yes ___ No ___
3. 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 ___
 - B. Is diagnosis locally advanced, unresectable (stage III) NSCLC? Yes ___ No ___
 - i. Has disease progressed during or following concurrent or sequential platinum-based chemoradiation therapy? Yes ___ No ___
 - C. Is diagnosis metastatic NSCLC? Yes ___ No ___
 - i. Is disease EGFR T790M mutation-positive? Yes ___ No ___
 - D. Is diagnosis locally advanced or metastatic non-squamous NSCLC? Yes ___ No ___
 - i. Will osimertinib be used as first-line treatment? Yes ___ No ___
 - ii. Will osimertinib be used in combination with pemetrexed and platinum-based (cisplatin or carboplatin) chemotherapy? 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: _____

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

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