

**Ibuprofen™ (taletrectinib) 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? Yes \_\_\_ No \_\_\_

B. Is disease positive for ROS1 rearrangements? 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 taletrectinib? Yes \_\_\_ No \_\_\_

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