

Padcev® (enfortumab vedotin-ejfv) Prior Authorization Form**Member Name:** _____ **Date of Birth:** _____ **Member ID#:** _____**Drug Information** **Physician billing (HCPCS code:** _____) **Pharmacy billing (NDC:** _____)**Dose:** _____ **Regimen:** _____ **Start Date (or date of next dose):** _____**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 indicate the diagnosis and information:

 Locally Advanced or Metastatic Urothelial Cancer

- Will Padcev® be used as a single agent? Yes ___ No ___
- Has the member previously received a programmed death 1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor and a platinum-containing chemotherapy in the neoadjuvant/adjuvant, locally advanced, or metastatic setting? Yes ___ No ___
- Has the member received at least 1 prior therapy? Yes ___ No ___
- Is the member eligible for cisplatin-containing chemotherapy? Yes ___ No ___
- Will Padcev® be used in combination with pembrolizumab? Yes ___ No ___

 Muscle Invasive Bladder Cancer (MIBC)

- Will Padcev® be used as neoadjuvant treatment and continued as adjuvant treatment after cystectomy? Yes ___ No ___
- Will Padcev® be used in combination with pembrolizumab or pembrolizumab berahyaluronidase alfa-pmph? Yes ___ No ___
- Is the member eligible for cisplatin-containing chemotherapy? Yes ___ No ___

For Continued Authorization:

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