

**Zynyz<sup>®</sup> (retifanlimab-dlwr) Prior Authorization Form**

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

**Drug Information**

**Physician billing (HCPCS code:** \_\_\_\_\_ **) Start Date (or date of next dose):** \_\_\_\_\_

**Dose:** \_\_\_\_\_ **Dosing 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 indicate the diagnosis and information:

**Merkel Cell Carcinoma (MCC)**

A. Is the diagnosis metastatic or recurrent locally advanced MCC? Yes \_\_\_ No \_\_\_

**Squamous Cell Carcinoma of the Anal Canal (SCAC)**

A. Used as first-line treatment in combination with carboplatin and paclitaxel? Yes \_\_\_ No \_\_\_

i. If yes, does member have inoperable locally recurrent or metastatic disease?

Yes \_\_\_ No \_\_\_

B. Used as a single agent? Yes \_\_\_ No \_\_\_

i. If yes, does member have locally recurrent or metastatic disease? Yes \_\_\_ No \_\_\_

ii. Used as subsequent or second-line therapy if progression or intolerance to platinum-based chemotherapy? Yes \_\_\_ No \_\_\_

iii. Has member received prior immunotherapy? Yes \_\_\_ No \_\_\_

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

**Additional Information:** \_\_\_\_\_

**For Continued Authorization:**

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

2. Does member have any evidence of progressive disease while on retifanlimab-dlwr? Yes \_\_\_ No \_\_\_

3. Has the member experienced adverse drug reactions related to retifanlimab-dlwr 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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