OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Epkinly® (epcoritamab-bysp) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Physician billing (HCPCS code: _____***)*** ***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 indicate the diagnosis and information:

☐ **Diffuse Large B-Cell Lymphoma (DLBCL)**

A. Is diagnosis relapsed or refractory DLBCL not otherwise specified, including DLBCL arising from indolent lymphomas and/or high-grade B-cell lymphomas? Yes☐ No☐

B. Has the member received 2 or more lines of systemic therapy? Yes☐ No☐

☐ **Follicular Lymphoma (FL)**

A. Is diagnosis relapsed or refractory FL? Yes☐ No☐

B. Has the member received 2 or more lines of systemic therapy? Yes☐ No☐

i. If yes, will Epkinly® be used as a single agent? Yes☐ No☐

C. Has the member received 1 or more lines of systemic therapy? Yes☐ No☐

i. If yes, will Epkinly® be used in combination with lenalidomide and rituximab? Yes☐ No☐

☐ **Other:** _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on Epkinly® therapy? Yes☐ No☐
3. Has member experienced any adverse drug reactions related to Epkinly® 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:	CONFIDENTIALITY NOTICE
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	*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.*