OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Imfinzi® (durvalumab) 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 (Initial approval will be for the duration of 6 months):

1. Please indicate the diagnosis and information:

☐ **Non-Small Cell Lung Cancer (NSCLC)**

A. Does member have resectable (tumors ≥4cm and/or node positive) NSCLC? Yes☐ No☐
   i. If yes, will durvalumab be used in combination with platinum-containing chemotherapy as neoadjuvant treatment before surgery, followed by single agent durvalumab as adjuvant treatment after surgery? Yes☐ No☐
   ii. Are there any epidermal growth factor receptor (EGFR) mutations or anaplastic lymphoma kinase (ALK) rearrangements? Yes☐ No☐

B. Does member have unresectable stage II or III NSCLC? Yes☐ No☐
   i. If yes, has member's disease progressed following concurrent platinum-based chemotherapy and radiation therapy? Yes☐ No☐

C. Does member have metastatic NSCLC? Yes☐ No☐
   i. If yes, does member have an epidermal growth factor (EGRF) mutation or anaplastic lymphoma kinase (ALK) genomic tumor aberrations? Yes☐ No☐
   ii. Will durvalumab be used in conjunction with Imjudo® (tremelimumab-actl) and platinum-based chemotherapy? Yes☐ No☐

☐ **Extensive-Stage Small Cell Lung Cancer (ES-SCLC)**

A. Will durvalumab be used in combination with etoposide and either cisplatin or carboplatin followed by single-agent maintenance? Yes☐ No☐

☐ **Limited-Stage Small Cell Lung Cancer (LS-SCLC)**

A. Has disease progressed following concurrent platinum-based chemotherapy and radiation therapy? Yes☐ No☐

B. Will durvalumab be used as a single agent? Yes☐ No☐

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

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information: *(continued)*

☐ **Bladder Cancer**
- A. Is diagnosis muscle invasive bladder cancer? Yes☐ No☐
  - i. If yes, will durvalumab be used in combination with gemcitabine and cisplatin as neoadjuvant treatment for 4 cycles? Yes☐ No☐
  - ii. Will durvalumab be followed by single-agent adjuvant treatment following radical cystectomy for up to 8 additional cycles? Yes☐ No☐
- B. Is diagnosis high risk, non-muscle-invasive bladder cancer (NMIBC)? Yes☐ No☐
  - i. If yes, will durvalumab be used in combination with Bacillus Calmette-Guerin (BCG)? Yes☐ No☐
  - ii. Has member received BCG previously? Yes☐ No☐

☐ **Hepatocellular Carcinoma (HCC)**
- A. Does member have a diagnosis of unresectable HCC? Yes☐ No☐
- B. Will durvalumab be used in combination with Imjudo® (tremelimumab-actl)? Yes☐ No☐
- C. Will durvalumab be used as a single agent? Yes☐ No☐

☐ **Endometrial Cancer**
- A. Is diagnosis primary advanced (FIGO measurable stage III/newly diagnosed stage IV) or recurrent endometrial cancer? Yes☐ No☐
- B. Mismatch repair deficient (dMMR)? Yes☐ No☐
- C. Will durvalumab be used in combination with carboplatin and paclitaxel followed by single-agent maintenance? Yes☐ No☐

☐ **Biliary Tract Cancer**
- A. Does member have locally advanced or metastatic biliary tract cancer? Yes☐ No☐
- B. Will durvalumab be used in combination with gemcitabine and cisplatin? Yes☐ No☐

☐ **Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma**
- A. Is disease resectable? Yes☐ No☐
- B. Is disease positive for programmed death ligand 1 (PD-L1) with a combined positive score (CPS) ≥1 or tumor area positivity (TAP) ≥1%? Yes☐ No☐
- C. Will durvalumab be used as perioperative treatment? Yes☐ No☐
  - i. If yes, will durvalumab be used in combination with fluorouracil, leucovorin, oxaliplatin, and docetaxel (FLOT) chemotherapy as neoadjuvant and adjuvant treatment? Yes☐ No☐
  - ii. Will durvalumab be used as single agent maintenance therapy following combination therapy with FLOT chemotherapy? Yes☐ No☐

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

Criteria

For Continued Authorization:

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

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