State of Oklahoma
SoonerCare

Rybrevant® (amivantamab-vmjw) & Rybrevant Faspro™ (amivantamab/hyaluronidase-lpuj) 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:

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

A. Is disease locally advanced or metastatic? Yes☐ No☐

B. Does tumor exhibit epidermal growth factor receptor (EGFR) exon 20 insertion mutations? Yes☐ No☐

C. Will the medication be used as first-line therapy in combination with carboplatin and pemetrexed? Yes☐ No☐

D. Will the medication be used as a single agent in disease that has progressed on or after platinum-based chemotherapy? Yes☐ No☐

E. Does tumor exhibit EGFR exon 19 deletion or exon 21 L858R mutations? Yes☐ No☐

F. Will the medication be used as first-line therapy in combination with lazertinib? Yes☐ No☐

G. Will the medication be used as subsequent therapy in combination with carboplatin and pemetrexed after progression on an EGFR tyrosine kinase inhibitor? Yes☐ No☐

☐ **If diagnosis is not listed above, please indicate diagnosis:** _____

Additional Information: _____

For Continued Authorization:

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