# State of Oklahoma
## SoonerCare
## Welireg® (belzutifan) Prior Authorization Form

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

## Drug Information

***Pharmacy billing (NDC:_____ ) Start Date (or date of next dose):_____***

***Dose:_____ Dosing Regimen:_____***

## Pharmacy Information

***Pharmacy NPI:_____ Pharmacy Name:_____***

***Pharmacy Phone:_____ Pharmacy Fax:_____***

## Prescriber Information

***Prescriber NPI:_____ Prescriber Name:_____***

***Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____***

## Criteria

**For Initial Authorization:**

1. **Please indicate the diagnosis and information:**

☐ **von Hippel-Landau (VHL) disease**

A. Please indicate any diagnosis below associated with VHL disease (please check all that apply):
- ☐ Renal cell carcinoma
- ☐ Central nervous system hemangioblastomas
- ☐ Pancreatic neuroendocrine tumor
- ☐ Other, please list:_____

B. Does the member require immediate surgery? Yes☐ No☐

☐ **Renal Cell Carcinoma (RCC)**

A. Is diagnosis advanced RCC with a clear cell component? Yes☐ No☐
   i. Has member received at least 2 lines of systemic therapy, including a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor and a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI)? Yes☐ No☐
   ii. Will belzutifan be used as a single agent? Yes☐ No☐

B. Is diagnosis RCC with a clear cell component? Yes☐ No☐
   i. Is disease intermediate-high or high risk of recurrence following nephrectomy or following nephrectomy and resection of metastatic lesions? Yes☐ No☐
   ii. Will belzutifan be used in combination with pembrolizumab? Yes☐ No☐

☐ **Pheochromocytoma or Paraganglioma (PPGL)**

A. Is diagnosis locally advanced, unresectable, or metastatic PPGL? Yes☐ No☐

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

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



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| University of Oklahoma College of Pharmacy<br>Pharmacy Management Consultants<br>Product Based Prior Authorization Unit<br><br>Fax: 1-800-224-4014<br>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.* |

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

## Criteria

**For Continued Authorization:**

1. Date of last dose: _____
2. Does the member have any evidence of progressive disease while on belzutifan? Yes ☐ No ☐
3. Has the member experienced any adverse drug reactions related to belzutifan 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 do not send in chart notes. They will be requested if necessary.*

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