OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Truqap® (capivasertib) Prior Authorization Form

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

Drug Information

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

Dose:_____ 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:

☐ **Breast Cancer**
- A. Is diagnosis locally advanced or metastatic breast cancer? Yes☐ No☐
- B. Is disease hormone receptor (HR)-positive? Yes☐ No☐
- C. Is disease human epidermal growth factor receptor 2 (HER2)-negative? Yes☐ No☐
- D. Will capivasertib be used in combination with fulvestrant? Yes☐ No☐
- E. Does disease contain 1 or more *PIK3CA/AKT1/PTEN*-alterations as detected by an FDA-approved test? Yes☐ No☐
- F. Has member progressed following at least 1 endocrine-based regimen in the metastatic setting? Yes☐ No☐
- G. Has member progressed within 12 months of completing adjuvant therapy? Yes☐ No☐

☐ **Prostate Cancer**
- A. Is diagnosis metastatic androgen pathway modulation-naïve or –sensitive (mAPMN/S) prostate cancer? Yes☐ No☐
- B. Will capivasertib be used in combination with abiraterone and prednisone? Yes☐ No☐
- C. Is disease PTEN-deficient as detected by an FDA-authorized test? Yes☐ No☐
- D. Concomitant treatment with a gonadotropin-releasing hormone (GnRH) analog or prior history of bilateral orchiectomy? Yes☐ No☐

☐ **Other** _____

For Continued Authorization:

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