OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Bizengri® (zenocutuzumab-zbco) Prior Authorization Form

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

Drug Information

Physician billing **(HCPCS code:**_____**)** ***Start Date:***_____

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. Is diagnosis advanced, unresectable or metastatic disease? Yes☐ No☐
2. Will Bizengri® be used as a single agent? Yes☐ No☐
3. Is disease neuregulin 1 *(NRG1)* gene fusion-positive? Yes☐ No☐
4. Please indicate the diagnosis and information:
   - ☐ **Non-Small Cell Lung Cancer (NSCLC)**
     a. Is there disease progression on or after prior systemic therapy? Yes☐ No☐
   - ☐ **Pancreatic Cancer**
     a. Is there disease progression on or after prior systemic therapy? Yes☐ No☐
   - ☐ **Cholangiocarcinoma**
   - ☐ **Other:** _____

Additional Information: _____

_____

For Continued Authorization:

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

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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