OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

Datroway® (datopotamab deruxtecan-dlnk) 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:***_____

Member's Weight: _____ ***Date Taken:*** _____

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. Will Datroway® be used as a single agent? Yes☐ No☐
2. Please indicate the diagnosis and information:

☐ **Breast Cancer**

- a. Is diagnosis unresectable or metastatic breast cancer? Yes☐ No☐
- b. Is disease hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)- negative? Yes☐ No☐
  - i. If yes, has member received prior endocrine-based therapy and chemotherapy? Yes☐ No☐
- c. Is disease triple-negative breast cancer (TNBC)? Yes☐ No☐
  - i. If yes, has member received prior systemic therapy? Yes☐ No☐
  - ii. Is member a candidate for programmed death 1 (PD-1)/programmed death ligand (PD-L1) inhibitor therapy? Yes☐ No☐
  - iii. Does member have a germline BRCA 1/2 pathogenic variant? Yes☐ No☐

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

- a. Is diagnosis locally advanced or metastatic NSCLC? Yes☐ No☐
- b. Is disease epidermal growth factor receptor (EGFR)-mutated? Yes☐ No☐
- c. Has member received prior EGFR-directed therapy and platinum-based chemotherapy? Yes☐ No☐

☐ **Other:**_____

For Continued Authorization:

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

DRAFT