OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare

Emrelis™ (telisotuzumab vedotin-tllv) Prior Authorization Form

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

Drug Information

☐ ***Physician billing (HCPCS code: _____)*** ☐ ***Pharmacy billing (NDC: _____)***

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 provide member's diagnosis:

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

A. Is diagnosis recurrent, advanced, or metastatic non-squamous NSCLC? Yes☐ No☐
B. Does member have disease with high c-Met/MET protein overexpression, defined as ≥50% of tumor cells with strong staining [immunohistochemistry (IHC) 3+]? Yes☐ No☐
C. Epidermal growth factor receptor (EGFR) wild-type? Yes☐ No☐
D. Has member received prior systemic therapy? Yes☐ No☐
E. Member's ECOG performance status: _____
F. Will Emrelis™ be used as a single agent? Yes☐ No☐
G. Member's weight: _____ (kg)

☐ **Other:** _____

For Continued Authorization:

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

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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