OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Ensacove™ (ensartinib) 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:**
   - ☐ **Non-Small Cell Lung Cancer (NSCLC)**
     - A. Is diagnosis locally advanced or metastatic NSCLC? Yes☐ No☐
     - B. Is disease anaplastic lymphoma kinase (ALK) positive? Yes☐ No☐
     - C. Will ensartinib be used as a single agent? Yes☐ No☐
     - D. Has member previously received an ALK inhibitor? Yes☐ No☐
   - ☐ **If diagnosis is not listed above, please indicate diagnosis:**_____

For Continued Authorization:

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