OKLAHOMA Health Care Authority

# State of Oklahoma
## SoonerCare
## Tarceva® (erlotinib) 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 (Initial approval will be for the duration of 6 months):**

1. Please indicate the diagnosis and information:

☐ **Non-Small Cell Lung Cancer (NSCLC)**
- a. Is disease recurrent or metastatic? Yes☐ No☐
- b. Epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) mutation detected? Yes☐ No☐
- c. Used as a single-agent? Yes☐ No☐
- d. Used in combination with ramucirumab (if T790M mutation negative)? Yes☐ No☐

☐ **Kidney Cancer**
- a. Is diagnosis advanced papillary renal cell carcinoma? Yes☐ No☐
- b. Non-clear cell histology? Yes☐ No☐
- c. Is disease relapsed or surgically unresectable stage IV? Yes☐ No☐
- d. Used in combination with bevacizumab? Yes☐ No☐

☐ **Bone Cancer—Chordoma**
- a. Is disease recurrent? Yes☐ No☐
- b. Will erlotinib be used as a single agent? Yes☐ No☐

☐ **Pancreatic Adenocarcinoma**
- a. Is disease locally advanced unresectable or metastatic? Yes☐ No☐
- b. Will erlotinib be used in combination with gemcitabine? Yes☐ No☐
- c. Member's ECOG performance status: _____

☐ **If answer is none of the above, please indicate diagnosis**:_____

Additional Information: _____

**For Continued Authorization:**

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

CONFIDENTIALITY NOTICE

*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.*