OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

Padcev® (enfortumab vedotin-ejfv) Prior Authorization Form

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

Drug Information

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

Dose:_____ ***Regimen:***_____ ***Start Date (or date of next dose):***_____

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 indicate the diagnosis and information:

☐ **Locally Advanced or Metastatic Urothelial Cancer**

a. Will Padcev® be used as a single agent? Yes☐ No☐
b. Has the member previously received a programmed death 1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor and a platinum-containing chemotherapy in the neoadjuvant/adjuvant, locally advanced, or metastatic setting? Yes☐ No☐
c. Has the member received at least 1 prior therapy? Yes☐ No☐
d. Is the member eligible for cisplatin-containing chemotherapy? Yes☐ No☐
e. Will Padcev® be used in combination with pembrolizumab? Yes☐ No☐

☐ **Muscle Invasive Bladder Cancer (MIBC)**

a. Will Padcev® be used as neoadjuvant treatment and continued as adjuvant treatment after cystectomy? Yes☐ No☐
b. Will Padcev® be used in combination with pembrolizumab? Yes☐ No☐

For Continued Authorization:

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