OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Trodelvy® (sacituzumab govitecan-hziy) 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:**

☐ **Breast Cancer**

A. For **triple-negative breast cancer**:
   1. Will Trodelvy® be used as first line therapy? Yes☐ No☐
      i. If yes, will Trodelvy® be used as monotherapy if member is not a candidate for PD-1 or PD-L1 inhibitor therapy? Yes☐ No☐
      ii. If yes, will Trodelvy® be used in combination with pembrolizumab for tumors expressing PD-L1 (CPS ≥10) as determined by an FDA-authorized test? Yes☐ No☐
   2. Will Trodelvy® be used as second line or later therapy? Yes☐ No☐
      i. If yes, is diagnosis unresectable locally advanced or metastatic disease? Yes☐ No☐
      ii. If yes, has member received ≥2 prior therapies, at least 1 of which was for metastatic disease? Yes☐ No☐

B. For **hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer**:
   1. Is diagnosis unresectable locally advanced or metastatic disease? Yes☐ No☐
   2. Has the member previously received endocrine-based therapy and ≥2 additional systemic therapies in the metastatic setting? Yes☐ No☐

☐ **If diagnosis is not listed, please provide member's diagnosis:_____**

DRAFT

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

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For Continued Authorization:

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

If yes, please specify adverse reactions:_____

Additional Information: _____

_____

_____

_____

_____

_____

_____

DRAFT

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.*

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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.*