OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

Zejula® (niraparib) 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:**

☐ **Castration-Resistant Prostate Cancer (CRPC)**

A. Is diagnosis metastatic CRPC? Yes☐ No☐
B. Presence of deleterious or suspected deleterious *BRCA* mutation based upon an FDA-approved test? Yes☐ No☐
C. Used in combination with abiraterone and prednisone or abiraterone acetate and methylprednisolone? Yes☐ No☐
D. Used in combination with a gonadotropin-releasing hormone (GnRH) analog or prior history of bilateral orchiectomy? Yes☐ No☐
E. Has member progressed on prior abiraterone therapy? Yes☐ No☐

☐ **Castration-Sensitive Prostate Cancer (CSPC)**

A. Is diagnosis metastatic CSPC with high-volume metastases? Yes☐ No☐
   i. Presence of visceral metastasis or ≥4 bone lesions with ≥1 beyond the vertebral bodies and pelvis? Yes☐ No☐
B. Presence of deleterious or suspected deleterious *BRCA* mutation based upon an FDA-approved test? Yes☐ No☐
C. Used in combination with abiraterone and prednisone or abiraterone acetate and methylprednisolone? Yes☐ No☐
D. Used in combination with a gonadotropin-releasing hormone (GnRH) analog or prior history of bilateral orchiectomy? Yes☐ No☐
E. Has member progressed on prior abiraterone therapy? Yes☐ No☐

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.

OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Zejula® (niraparib) Prior Authorization Form

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

Criteria

For Initial Authorization: *(continued)*

1. **Please indicate the diagnosis and information:**

☐ **Ovarian, Fallopian Tube, or Primary Peritoneal Cancer**

A. Used for maintenance treatment of advanced disease? Yes☐ No☐
B. Is disease advanced or recurrent? Yes☐ No☐
C. Is disease in a complete or partial response to platinum chemotherapy? Yes☐ No☐
D. Is niraparib being used for maintenance following recurrence? Yes☐ No☐
   i. If yes, is disease positive for a BRCA mutation? Yes☐ No☐
E. Will niraparib be used as a single-agent? Yes☐ No☐

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

For Continued Authorization:

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

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.