

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

Drug Information

Physician billing (HPCS code: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

Billing Provider Information

SoonerCare Provider ID: _____ Provider Name: _____

Provider Phone: _____ Provider 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 provide member's most recent weight (kg): _____ Date Determined: _____

2. Please indicate the diagnosis and information:

Merkel Cell Carcinoma (MCC)

A. Is diagnosis metastatic MCC? Yes ___ No ___

Urothelial Carcinoma

A. Is diagnosis locally advanced or metastatic urothelial carcinoma? Yes ___ No ___

B. Has disease progressed during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy? Yes ___ No ___

C. Will avelumab be used as maintenance therapy? Yes ___ No ___

D. Has disease progressed on a first-line platinum-containing regimen? Yes ___ No ___

Renal Cell Carcinoma (RCC)

A. Is diagnosis advanced RCC? Yes ___ No ___

B. Will avelumab be used as first-line treatment? Yes ___ No ___

C. Will avelumab be used in combination with axitinib? Yes ___ No ___

If diagnosis is not listed above, please provide diagnosis: _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on avelumab? Yes ___ No ___

3. Has the member experienced adverse drug reactions related to avelumab 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

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