

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

Drug Information

Pharmacy billing (NDC: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

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:

Metastatic Non-Small Cell Lung Cancer (NSCLC)

A. Has member received prior epidermal growth factor receptor (EGFR) therapy for metastatic disease? Yes ___ No ___

B. EGFR exon 19 deletion? Yes ___ No ___

C. Exon 21 L858R substitution mutations? Yes ___ No ___

Other, please provide diagnosis: _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does patient have any evidence of progressive disease while on dacomitinib therapy? Yes ___ No ___

3. Has the member experienced any adverse drug reactions related to dacomitinib 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

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