State of Oklahoma
SoonerCare
Lenvima® (Lenvatinib) Prior Authorization Form

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

Drug Information

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

Dose: _____ ***Regimen:*** _____

Billing Provider 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:**
   - ❑ **Endometrial Carcinoma**
     - A. Is disease advanced with progression on prior systemic therapy? Yes ☐ No ☐
     - B. Is member a candidate for curative surgery or radiation? Yes ☐ No ☐
     - C. Is disease microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)? Yes ☐ No ☐
     - A. Will lenvatinib be used in combination with pembrolizumab? Yes ☐ No ☐
   - ❑ **Hepatocellular Carcinoma (HCC)**
     - A. Is disease unresectable? Yes ☐ No ☐
     - B. Will lenvatinib be used as first-line treatment? Yes ☐ No ☐
   - ❑ **Renal Cell Carcinoma (RCC)**
     - A. Is disease advanced? Yes ☐ No ☐
     - B. Will lenvatinib be used following 1 prior anti-angiogenic therapy? Yes ☐ No ☐
     - C. Will lenvatinib be used in combination with everolimus? Yes ☐ No ☐
   - ❑ **Differentiated Thyroid Cancer (DTC)**
     - A. Is disease locally recurrent or metastatic? Yes ☐ No ☐
     - B. Has disease progressed on prior treatment? Yes ☐ No ☐
     - C. Is disease radioactive iodine-refractory? Yes ☐ No ☐
   - ❑ **If diagnosis is not listed above, please indicate diagnosis:** _____

For Continued Authorization:

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

CONFIDENTIALITY NOTICE