OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Xalkori® (Crizotinib) 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

Provider NPI: _____ ***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 indicate diagnosis and information:
   - ❑ **Non-Small Cell Lung Cancer (NSCLC)**
     - A. Metastatic NSCLC (first-line or subsequent therapy)? Yes ☐ No ☐
     - B. Is disease anaplastic lymphoma kinase (ALK) or *ROS1* positive? Yes ☐ No ☐
     - C. MET amplification? Yes ☐ No ☐
     - D. Will crizotinib be used as a single-agent only? Yes ☐ No ☐
   - ❑ **Soft Tissue Sarcoma**
     - A. Diagnosis of soft tissue sarcoma—Inflammatory Myofibroblastic Tumor (IMT)? Yes ☐ No ☐
     - B. Is disease ALK positive? Yes ☐ No ☐
     - C. Will crizotinib be used as a single-agent only? Yes ☐ No ☐
   - ❑ **Anaplastic Large Cell Lymphoma (ALCL)**
     - A. Is disease ALK positive? Yes ☐ No ☐
     - B. Is disease relapsed or refractory? Yes ☐ No ☐
     - C. Will crizotinib be used as second-line or initial palliative intent therapy and subsequent therapy? Yes ☐ No ☐
   - ❑ **Other, please provide diagnosis:** _____

Additional Information: _____

_____

For Continued Authorization:

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