

**State of Oklahoma
Oklahoma Health Care Authority
Gilotrif® (Afatinib) 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? Yes ___ No ___
 - B. Epidermal growth factor receptor (EGFR) mutation detected? Yes ___ No ___
 - C. Afatinib used in the first-line setting? Yes ___ No ___
 - D. Afatinib used as a single-agent? Yes ___ No ___
 - E. Progressed following platinum-based chemotherapy? Yes ___ No ___
 - F. Afatinib used in combination with cetuximab in patients with a known sensitizing EGFR mutation who are T790M negative? Yes ___ No ___
- Head and Neck Cancer
 - A. Disease progression on or after platinum containing chemotherapy? Yes ___ No ___
 - B. Non-nasopharyngeal cancer? Yes ___ No ___
 - C. Newly diagnosed T4b, any N, M0 disease, unresectable nodal disease with no metastases, or member unfit for surgery? Yes ___ No ___
 - D. Metastatic (M1) disease at initial presentation, recurrent/persistent disease with distant metastases, or unresectable locoregional recurrence or second primary with prior radiation therapy (RT)? Yes ___ No ___
 - E. Unresectable locoregional recurrence without prior RT? Yes ___ No ___
 - F. Performance status (PS): _____
 - G. Afatinib used as a single-agent? 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 afatinib? Yes ___ No ___
3. Has the member experienced adverse drug reactions related to afatinib 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.

<p align="center">PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</p> <p align="center">University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p align="center">Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p align="center">CONFIDENTIALITY NOTICE</p> <p><i>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.</i></p>
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