OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare

Alecensa® (Alectinib) Prior Authorization Form

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

Drug Information

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

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

Pharmacy Information

Pharmacy NPI:_____ ***Pharmacy Name:***_____

Pharmacy Phone:_____ ***Pharmacy 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. Diagnosis of non-small cell lung cancer (NSCLC)? Yes☐ No☐
   A. If answer is 'yes' to question 1, please check all of the following that apply:
   - ☐ Recurrent or metastatic NSCLC
   - ☐ Resected NSCLC (tumors ≥4cm or node positive)
   - ☐ Anaplastic lymphoma kinase (ALK) positivity
   - ☐ Alectinib will be used as first-line therapy
   - ☐ Alectinib will be used for recurrent disease
   - ☐ Alectinib will be used as a single-agent only
   - ☐ Alectinib will be used as adjuvant treatment
2. If answer is 'no' to question 1, please provide diagnosis:_____

Additional Information:_____

_____

For Continued Authorization:

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