OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Krazati® (Adagrasib) 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:**

☐ **Non-Small Cell Lung Cancer (NSCLC)**
- A. Is diagnosis recurrent, advanced, or metastatic NSCLC? Yes☐ No☐
- B. Is there the presence of KRAS G12C mutation in tumor or plasma specimen as determined by an FDA approved test? Yes☐ No☐
- C. Has the member received at least 1 prior systemic therapy? Yes☐ No☐
- D. Will adagrasib be used as a single agent? Yes☐ No☐

☐ **Colorectal Cancer (CRC)**
- A. Is diagnosis locally advanced or metastatic CRC? Yes☐ No☐
- B. Is there the presence of KRAS G12C mutation in tumor specimen as determined by an FDA approved test? Yes☐ No☐
- C. Will adagrasib be used in combination with cetuximab? Yes☐ No☐
- D. Has member received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy? Yes☐ No☐

☐ **If diagnosis is not listed above, please indicate diagnosis:**_____

Additional Information:_____

_____

For Continued Authorization:

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