

State of Oklahoma
SoonerCare
Epkinly® (Epcoritamab-bysp) Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code: _____ **) Start Date (or date of next dose):** _____

Dose: _____ **Dosing 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:

1. Please indicate the diagnosis and information:

Lymphoma

A. Is diagnosis relapsed or refractory follicular lymphoma (FL) or diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including DLBCL arising from indolent lymphomas and/or high-grade B-cell lymphomas? Yes ___ No ___

B. Has the member received 2 or more lines of systemic therapy? Yes ___ No ___

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

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on epcoritamab-bysp therapy?

Yes ___ No ___

3. Has member experienced any adverse drug reactions related to epcoritamab-bysp 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. 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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