# State of Oklahoma
## SoonerCare
## Lazcluze™ (lazertinib) 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:**

1. Please indicate the diagnosis and information:
   - ☐ **Non-Small Cell Lung Cancer (NSCLC)**
   - ☐ **Other:** _____
2. Is diagnosis locally advanced or metastatic NSCLC? Yes☐ No☐
3. Does tumor exhibit epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations? Yes☐ No☐
4. Will lazertinib be used as first-line treatment in combination with amivantamab? Yes☐ No☐

Additional Information: _____

_____

**For Continued Authorization:**

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