OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Tagrisso® (Osimertinib) Prior Authorization Form

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

Drug Information

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

Dose: _____ ***Dosing 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. Will osimertinib be used as a single agent? Yes☐ No☐
2. Is disease epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R mutation-positive? Yes☐ No☐
3. Please indicate diagnosis and information:
   - ☐ **Non-Small Cell Lung Cancer (NSCLC)**
     - A. Is diagnosis non-metastatic NSCLC? Yes☐ No☐
       - i. Will osimertinib be used as adjuvant therapy following tumor resection? Yes☐ No☐
     - B. Is diagnosis locally advanced, unresectable (stage III) NSCLC? Yes☐ No☐
       - i. Has disease progressed during or following concurrent or sequential platinum-based chemoradiation therapy? Yes☐ No☐
     - C. Is diagnosis metastatic NSCLC? Yes☐ No☐
       - i. Is disease EGFR T790M mutation-positive? Yes☐ No☐
     - D. Is diagnosis locally advanced or metastatic non-squamous NSCLC? Yes☐ No☐
       - i. Will osimertinib be used as first-line treatment? Yes☐ No☐
       - ii. Will osimertinib be used in combination with pemetrexed and platinum-based (cisplatin or carboplatin) chemotherapy? Yes☐ No☐
   - ☐ **If diagnosis is not listed above, please provide diagnosis:** _____

Additional Information: _____

For Continued Authorization:

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