OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

Ziihera® (zanidatamab-hrii) Prior Authorization Form

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

Drug Information

☐ ***Physician billing (HCPCS code:_____)*** ☐ ***Pharmacy billing (NDC:_____)***

Dose:_____ Regimen:_____ Start Date (or date of next dose):_____

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: *(please complete and return both pages)*

1. Please indicate the diagnosis and information:

☐ **Biliary Tract Cancer (BTC)**

a. Is diagnosis unresectable or metastatic disease? Yes☐ No☐

b. Is disease human epidermal growth factor receptor 2 (HER2)-positive immunohistochemistry (IHC) 3+? Yes☐ No☐

c. Will Ziihera® be used for subsequent-line therapy? Yes☐ No☐

d. Will Ziihera® be used as a single agent? Yes☐ No☐

☐ **Gastric, Gastroesophaeal Junction (GEJ), or Esophageal Adenocarcinoma**

a. Is diagnosis unresectable locally advanced or metastatic disease? Yes☐ No☐

b. Is disease human epidermal growth factor receptor 2 (HER2)-positive immunohistochemistry (IHC) 3+? Yes☐ No☐

i. If yes, Will Ziihera® be used as first-line treatment in combination with fluoropyrimidine– and platinum-containing chemotherapy? Yes☐ No☐

c. Is disease HER2-positive IHC 3+ or IHC 2+/in situ hybridization (ISH)-positive? Yes☐ No☐

i. If yes, Will Ziihera® be used as first-line treatment in combination with fluoropyrimidine– and platinum-containing chemotherapy and tislelizumab-jsgr? Yes☐ No☐

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.*

DRAFT

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

Criteria

For Continued Authorization:

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

If yes, please specify adverse reactions: _____

Additional Information: _____

_____

_____

_____

_____

DRAFT

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.*

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