OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare Gavreto® (Pralsetinib) Prior Authorization Form

SoonerSelect | aetna

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 tumor rearranged during transfection (RET) fusion positive? Yes☐ No☐

C. Will pralsetinib be used as a single agent? Yes☐ No☐

☐ **Thyroid Cancer**

A. Is disease advanced or metastatic? Yes☐ No☐

B. Is diagnosis RET-mutant medullary thyroid cancer requiring systemic therapy? Yes☐ No☐

C. Is diagnosis RET fusion-positive thyroid cancer? Yes☐ No☐

i. If yes, does member require systemic therapy? Yes☐ No☐

ii. Is radioactive iodine appropriate for this member? Yes☐ No☐

a. If appropriate, is member refractory to radioactive iodine? Yes☐ No☐

D. Will pralsetinib be used as a single agent? 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 pralsetinib? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to pralsetinib 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.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**	CONFIDENTIALITY NOTICE *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.*