OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
Lumakras™ (Sotorasib) 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: _____ ***Dosing 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 disease locally advanced or metastatic? Yes☐ No☐
     - B. Is there presence of KRAS G12C mutation? Yes☐ No☐
     - C. Has disease progressed on at least 1 prior systemic therapy ? Yes☐ No☐
     - D. Will Lumakras™ 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 the member have any evidence of progressive disease while on sotorasib? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to sotorasib 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.*

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.**	