OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Lynparza® (Olaparib) Prior Authorization Form

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

Page 1 of 2–Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization:

1. Please indicate diagnosis and information:

❑ **Advanced Recurrent/Refractory Ovarian, Fallopian Tube, or Primary Peritoneal Cancer Treatment**

A. Presence of deleterious or suspected deleterious germline BRCA mutation (*gBRCAm*)? Yes☐ No☐

B. Was member previously treated with 2 or more lines of prior chemotherapy? Yes☐ No☐

i. If yes, please provide prior chemotherapy regimens:_____

_____

❑ **Maintenance Treatment of Advanced Ovarian, Fallopian Tube, or Primary Peritoneal Cancer**

A. Is disease in complete or partial response to primary chemotherapy? Yes☐ No☐

i. Will olaparib be used as a single-agent in deleterious or suspected deleterious *gBRCAm* or somatic BRCA-mutated (*sBRCAm*) disease? Yes☐ No☐

ii. Will olaparib be used in combination with bevacizumab following a primary therapy regimen that included bevacizumab? Yes☐ No☐

B. Is disease in complete or partial response to second-line or greater platinum-based chemotherapy? Yes☐ No☐

❑ **Breast Cancer**

A. Is disease human epidermal growth factor receptor 2 (HER2)-negative? Yes☐ No☐

B. Is disease high-risk early breast cancer previously treated with neoadjuvant or adjuvant chemotherapy? Yes☐ No☐

i. Will olaparib be used in the adjuvant setting? Yes☐ No☐

ii. Positive test for *gBRCAm*? Yes☐ No☐

C. Is diagnosis metastatic breast cancer? Yes☐ No☐

i. Has member shown progression on previous chemotherapy? Yes☐ No☐

ii. Is disease hormone receptor (HR)-positive? Yes☐ No☐

1. Has member failed prior endocrine therapy or considered to not be a candidate for endocrine therapy? Yes☐ No☐

❑ **Pancreatic Cancer**

A. Is diagnosis metastatic pancreatic adenocarcinoma with known germline BRCA1/BRCA2 mutation? Yes☐ No☐

B. Will olaparib be used as a single agent for maintenance therapy? Yes☐ No☐

C. Has member progressed on at least 16 weeks of first-line platinum-based chemotherapy? Yes☐ No☐

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**.

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Criteria

Page 2 of 2– Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization, continued:

1. Please indicate diagnosis and information, continued:

❑ **Prostate Cancer**

A. Is diagnosis metastatic castration-resistant prostate cancer? Yes☐ No☐
B. Has member failed previous first-line therapy? Yes☐ No☐
C. Will olaparib be used as a single-agent? Yes☐ No☐
   i. If no, will olaparib be used with a gonadotropin-releasing hormone (GnRH) analog? Yes☐ No☐
   ii. If no, does member have a prior history of bilateral orchiectomy? Yes☐ No☐
D. Is disease positive for a mutation in a homologous recombination gene? Yes☐ No☐

❑ **Other, please provide diagnosis:** _____

Additional Information: _____

_____

_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on olaparib? Yes☐ No☐
3. Has member experienced adverse drug reactions related to olaparib 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 all pages will result in processing delays.

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