OKLAHOMA Health Care Authority

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State of Oklahoma SoonerCare
Orserdu™ (Elacestrant) 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

For Initial Authorization:

1. **Please indicate the diagnosis and information:**
   - ☐ **Advanced or metastatic breast cancer**
     - A. Is disease estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative? Yes☐ No☐
     - B. Is tumor positive for ESR1-mutation? Yes☐ No☐
     - C. If female, is member postmenopausal? Yes☐ No☐
     - D. Has disease progressed after at least 1 prior endocrine therapy? 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 elacestrant? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to elacestrant 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. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.