OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Rozlytrek® (Entrectinib) 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

Provider NPI:_____ ***Provider Name:***_____

Provider Phone:_____ ***Provider 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 metastatic? Yes☐ No☐
B. Is tumor *ROS1*-positive? Yes☐ No☐
C. Will entrectinib be used as a single agent? Yes☐ No☐

☐ **Solid Tumors**

A. Does diagnosis include *NTRK* gene fusion without a known acquired resistance mutation? Yes☐ No☐
B. Is disease metastatic? Yes☐ No☐
C. Is member a surgical candidate? Yes☐ No☐
D. Has disease progressed following treatment? Yes☐ No☐
E. Is a satisfactory alternative therapy available? Yes☐ No☐
F. Will entrectinib be used as single agent? Yes☐ No☐

☐ **If answer is none of the above, please indicate diagnosis:**_____

Additional Information:_____

For Continued Authorization:

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