OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
Rubraca® (Rucaparib) Prior Authorization Form

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Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

Pharmacy Billing (NDC:_____***) Start Date (or date of next dose):***_____

Dose:_____ ***Regimen:***_____

Pharmacy 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:**

☐ **Ovarian, Fallopian Tube, or Primary Peritoneal Cancer**

A. Will rucaparib be used as maintenance treatment of recurrent disease? Yes☐ No☐
B. Is disease in a complete or partial response to platinum-based chemotherapy? Yes☐ No☐
C. Is disease positive for a BRCA mutation? Yes☐ No☐
D. Will recuparib be used as a single-agent? Yes☐ No☐

☐ **Prostate Cancer**

A. Is diagnosis metastatic, castration-resistant prostate cancer? Yes☐ No☐
B. Has member failed previous first-line therapy? Yes☐ No☐
C. Will rucaparib 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 BRCA1 or BRCA2 mutation? 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 rucaparib? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to rucaparib therapy? Yes☐ No☐

*If yes, please specify adverse reactions:*_____

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.**