OKLAHOMA Health Care Authority

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State of Oklahoma
SoonerCare
Rybrevant® (Amivantamab-vmjw) Prior Authorization Form

***Member Name:*____________________ *Date of Birth:*____________ *Member ID#:*______________**

Drug Information

***Physician billing (HCPCS code:*________________*) 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 locally advanced or metastatic? Yes____ No____
     - B. Does tumor exhibit epidermal growth factor receptor (EGFR) exon 20 insertion mutations? Yes____ No____
     - C. Will Rybrevant® be used as first-line therapy in combination with carboplatin and pemetrexed? Yes____ No____
     - D. Will Rybrevant® be used as a single agent in disease that has progressed on or after platinum-based chemotherapy? Yes____ No____
     - E. Does tumor exhibit EGFR exon 19 deletion or exon 21 L858R mutations? Yes____ No____
     - F. Will Rybrevant® be used as subsequent therapy in combination with carboplatin and pemetrexed after progression on osimertinib? Yes____ No____
   - ❑ **If diagnosis is not listed above, please indicate diagnosis:**______________________________

Additional Information:____

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For Continued Authorization:

1. Date of last dose:_____________________
2. Does the member have any evidence of progressive disease while on amivantamab-vmjw? Yes___ No___
3. Has the member experienced any adverse drug reactions related to amivantamab-vmjw 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. *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.	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.*