OKLAHOMA Health Care Authority

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State of Oklahoma SoonerCare Tukysa® (Tucatinib) 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:

☐ **Breast Cancer**

A. Does member have advanced, unresectable or metastatic breast cancer? Yes☐ No☐

B. Will tucatinib be used in combination with trastuzumab and capecitabine? Yes☐ No☐

C. Does member have Human Epidermal Receptor Type 2 (HER2)-positive disease? Yes☐ No☐

D. Is tucatinib to follow progression on 1 or more prior anti-HER2 regimens in the metastatic setting? Yes☐ No☐

☐ **Colorectal Cancer**

A. Does member have RAS wild-type HER2-positive unresectable or metastatic colorectal cancer? Yes☐ No☐

B. Has cancer progressed following treatment with fluoropyrimidine, oxaliplatin, and irinotecan-based chemotherapy? Yes☐ No☐

C. Will tucatinib be used in combination with trastuzumab? Yes☐ No☐

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

Additional Information:____

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For Continued Authorization:

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

*If yes, please specify adverse reactions:*____

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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.**	<u>CONFIDENTIALITY NOTICE</u> *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.*