OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare

Alecensa® (Alectinib) Prior Authorization Form

***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 (Initial approval will be for the duration of 6 months):

1. Diagnosis of non-small cell lung cancer (NSCLC)? Yes____ No____
   A. If answer is 'yes' to question 1, please check all of the following that apply:
   - ❑ Recurrent or metastatic NSCLC
   - ❑ Resected NSCLC (tumors ≥4cm or node positive)
   - ❑ Anaplastic lymphoma kinase (ALK) positivity
   - ❑ Alectinib will be used as first-line therapy
   - ❑ Alectinib will be used for recurrent disease
   - ❑ Alectinib will be used as a single-agent only
   - ❑ Alectinib will be used as adjuvant treatment
2. If answer is 'no' to question 1, please provide diagnosis:______________________________

Additional Information:____
____

For Continued Authorization:

1. Date of last dose:_____________________________
2. Does member have any evidence of progressive disease while on alectinib? Yes____ No____
3. Has the member experienced adverse drug reactions related to alectinib 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. 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.*