OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Augtyro™ (repotrectinib) 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:

1. Please indicate diagnosis and information:

☐ **Non-Small Cell Lung Cancer (NSCLC)**

A. Is NSCLC locally advanced or metastatic? Yes☐ No☐
B. Is NSCLC ROS1-positive? Yes☐ No☐
C. Will repotrectinib be used as a single agent? Yes☐ No☐

☐ **Other:** _____

Additional information: _____

_____

For Continued Authorization:

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

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.**