OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

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Bizengri® (zenocutuzumab-zbco) Prior Authorization Form

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

Drug Information

Physician billing **(HCPCS code:**_____**)** ***Start Date:***_____

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)**
   - ☐ **Pancreatic Cancer**
   - ☐ **Other:** _____
2. Is disease advanced, unresectable or metastatic NSCLC or pancreatic adenocarcinoma? Yes☐ No☐
3. Is disease neuregulin 1 *(NRG1)* gene fusion-positive? Yes☐ No☐
4. Is there disease progression on or after prior systemic therapy? Yes☐ No☐
5. Will Bizengri® be used as a single agent? Yes☐ No☐

Additional information: _____

_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on Bizengri®? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to Bizengri®? 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. Please do not send in chart notes. Specific information will be requested if necessary.*

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.	