OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

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Lazcluze™ (lazertinib) 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 the diagnosis and information:
   - ☐ **Non-Small Cell Lung Cancer (NSCLC)**
   - ☐ **Other:** _____
2. Is diagnosis locally advanced or metastatic NSCLC? Yes☐ No☐
3. Does tumor exhibit epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations? Yes☐ No☐
4. Will lazertinib be used as first-line treatment in combination with amivantamab? Yes☐ No☐

Additional Information:_____

_____

For Continued Authorization:

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