OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare Margenza® (Margetuximab-cmkb) Prior Authorization Form

SoonerSelect | aetna

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

Drug Information

☐**Physician billing (HCPCS code:**_____**)** ☐**Pharmacy billing (NDC:**_____**)**

Dose:_____ ***Regimen:***_____ ***Start Date (or date of next dose):***_____

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:**
   - ☐ **Breast Cancer**
     - A. Is disease metastatic? Yes☐ No☐
     - B. Is disease human epidermal receptor type 2 (HER2)-positive? Yes☐ No☐
     - C. Has member received 2 or more prior anti-HER2 regimens with at least 1 treatment for metastatic disease? Yes☐ No☐
     - D. Will margetuximab-cmkb be used in combination with chemotherapy (capecitabine, eribulin, gemcitabine, or vinorelbine)? Yes☐ No☐
   - ☐ **If answer is none of the above, please indicate diagnosis:**_____

Additional Information:_____

_____

For Continued Authorization:

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

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.**