OKLAHOMA Health Care Authority

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State of Oklahoma SoonerCare

Talzenna® (talazoparib) 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:

☐ **Breast Cancer**

A. Metastatic or recurrent breast cancer? Yes☐ No☐
B. Human epidermal growth factor receptor 2 (HER2)-status? Positive☐ Negative☐
C. Positive test for BRCA 1/2-germline mutation? Yes☐ No☐
D. Hormone receptor (HR)-positive? Yes☐ No☐
   i. If yes, has member failed prior endocrine therapy or considered to not be a candidate for endocrine therapy? Yes☐ No☐
E. Hormone receptor (HR)-negative? Yes☐ No☐
F. Does member have symptomatic visceral disease? Yes☐ No☐
G. Will talazoparib be used as a single agent? Yes☐ No☐

☐ **Prostate Cancer**

A. Is disease metastatic, castration-resistant prostate cancer? Yes☐ No☐
B. Is disease homologous recombination repair (HRR) gene-mutated? Yes☐ No☐
C. Will talazoparib be used in combination with enzalutamide? Yes☐ No☐

☐ **If diagnosis is not listed 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 talazoparib? Yes☐ No☐
3. Has member experienced adverse drug reactions related to talazoparib 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.

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.**	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.*