State of Oklahoma
SoonerCare
Tivdak® (Tisotumab Vedotin-tftv)
Prior Authorization Form

***Member Name:*______________________ *Date of Birth:*____________ *Member ID#:*________________**

Drug Information

❑Physician billing (HCPCS code:___________) ❑Pharmacy billing (NDC:_____________________)

***Start Date (or date of next dose):*______________ *Dose:*____________________**

***Dosing Regimen: Cycles 1 & 2*______________________ Subsequent Cycles:______________________**

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:

- ❑ **Cervical Cancer**
  - A. Is disease recurrent or metastatic? Yes____ No____
  - B. Has disease progressed on or after chemotherapy? Yes____ No____
- ❑ **If diagnosis is not listed of the above, please indicate diagnosis:**_____________________

Additional Information:____

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For Continued Authorization:

1. Date of last dose:______________________________
2. Does the member have any evidence of progressive disease while on Tivdak®? Yes____ No____
3. Has the member experienced adverse drug reactions related to Tivdak® therapy? Yes____ No____

If yes, please specify adverse reactions: ____

Additional Information:____

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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.**	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.*