State of Oklahoma
Oklahoma Health Care Authority

Vitrakvi® (Larotrectinib) Prior Authorization Form

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

Drug Information

Pharmacy billing **(NDC:**_____**)** ***Start Date (or date of next dose):***_____

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 diagnosis and information:
   - ❑ **Solid tumors With Neurotrophic Receptor Tyrosine Kinase (NTRK) Gene Fusion**
     - A. Does diagnosis include a known acquired resistance mutation? Yes☐ No☐
     - B. Is disease metastatic? Yes☐ No☐
     - C. Is surgical resection contraindicated? Yes☐ No☐
     - D. If thyroid carcinoma, is disease radioactive iodine refractory? Yes☐ No☐ N/A☐
     - E. Are there any satisfactory alternative treatments? Yes☐ No☐
     - F. Has member experienced disease progression following acceptable alternative treatments? Yes☐ No☐
   - ❑ **Other, please provide diagnosis:**_____

Additional Information:_____

_____

_____

For Continued Authorization:

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

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 throughCoverMyMeds® 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.*

OHCA Approved – 04/22/2019