OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Vyloy® (zolbetuximab-clzb) Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code: _____***)*** ***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 the diagnosis and information:

☐ **Locally advanced unresectable or metastatic gastric or gastroesophageal junction (GEJ) adenocarcinoma**

A. Is disease HER2-negative? Yes☐ No☐
B. Is disease claudin (CLDN) 18.2 positive (defined as ≥75% of tumor cells demonstrating moderate to strong membranous CLDN18 immunohistochemical staining)? Yes☐ No☐
C. Will Vyloy® be used for first-line treatment? Yes☐ No☐
D. Will Vyloy® be used in combination with fluoropyrimidine- and platinum-containing chemotherapy? Yes☐ No☐
E. Please provide member's recent body surface area (BSA): _____ Date Taken: _____

☐ **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 Vyloy®? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to Vyloy® 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. *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. 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.*