State of Oklahoma
Oklahoma Health Care Authority

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# Zykadia® (Ceritinib) 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 (Initial approval will be for the duration of 6 months):**

1. Please indicate diagnosis and information:
   - ☐ Non-Small Cell Lung Cancer (NSCLC)
     - A. Metastatic NSCLC? Yes____ No____
     - B. Anaplastic lymphoma kinase (ALK) positivity? Yes____ No____
     - C. Ceritinib used as a single-agent? Yes____ No____
   - ☐ Soft Tissue Sarcoma-Inflammatory Myofibroblastic Tumor (IMT)
     - A. Anaplastic lymphoma kinase (ALK) positivity? Yes____ No____
     - B. Ceritinib used as a single-agent? 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 ceritinib? Yes____ No____
3. Has the member experienced adverse drug reactions related to ceritinib 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.