OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Zynyz™ (Retifanlimab-dlwr) Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code:_____) Start Date (or date of next dose):_____

Dose:_____ Dosing 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:

☐ **Merkel Cell Carcinoma (MCC)**
   A. Is the diagnosis metastatic or recurrent locally advanced MCC? 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 retifanlimab-dlwr?
   Yes☐ No☐
3. Has the member experienced adverse drug reactions related to retifanlimab-dlwr 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. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma**.	