OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Cosela™ (Trilaciclib) 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:

- ❑ **Extensive-Stage Small Cell Lung Cancer (ES-SCLC)**
  - A. Is member is undergoing myelosuppressive chemotherapy with 1 of the following:
    - _____ A platinum (carboplatin or cisplatin) and etoposide-containing regimen
    - _____ A topotecan-containing regimen
    - _____ Other, please provide chemotherapy regimen:_____
      _____

- ❑ **If diagnosis is not listed above, please indicate diagnosis:**_____

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. *Failure to complete this form in full will result in processing delays.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE