

State of Oklahoma
SoonerCare
Tivdak[®] (Tisotumab Vedotin-tftv)
Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code: _____) Pharmacy billing (NDC: _____)

Start Date (or date of next dose): _____ Dose: _____

Dosing Regimen: Cycles 1 & 2 _____ Subsequent Cycles: _____

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:

Cervical Cancer

A. Is disease recurrent or metastatic? Yes ___ No ___

B. Has disease progressed on or after chemotherapy? Yes ___ No ___

If diagnosis is not listed of the above, please indicate diagnosis: _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does the member have any evidence of progressive disease while on Tivdak[®]? Yes ___ No ___

3. Has the member experienced adverse drug reactions related to Tivdak[®] 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. 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

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