OKLAHOMA
Health Care Authority

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