OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

Lynparza® (Olaparib) 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

Pharmacy NPI:_____ ***Pharmacy Name:***_____

Pharmacy Phone:_____ ***Pharmacy Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Criteria

Page 1 of 2–Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.

For Initial Authorization:

1. Please indicate diagnosis and information:

❑ **Advanced Recurrent/Refractory Ovarian, Fallopian Tube, or Primary Peritoneal Cancer Treatment**

A. Presence of deleterious or suspected deleterious germline BRCA mutation (*gBRCAm*)? Yes____ No____

B. Was member previously treated with 2 or more lines of prior chemotherapy? Yes____ No____

i. If yes, please provide prior chemotherapy regimens:_____

_____

❑ **Maintenance Treatment of Advanced Ovarian, Fallopian Tube, or Primary Peritoneal Cancer**

A. Is disease in complete or partial response to primary chemotherapy? Yes____ No____

i. Will olaparib be used as a single-agent in deleterious or suspected deleterious *gBRCAm* or somatic BRCA-mutated (*sBRCAm*) disease? Yes____ No____

ii. Will olaparib be used in combination with bevacizumab following a primary therapy regimen that included bevacizumab? Yes____ No____

B. Is disease in complete or partial response to second-line or greater platinum-based chemotherapy? Yes___ No___

❑ **Breast Cancer**

A. Is disease human epidermal growth factor receptor 2 (HER2)-negative? Yes____ No____

B. Is disease high-risk early breast cancer previously treated with neoadjuvant or adjuvant chemotherapy? Yes____ No____

i. Will olaparib be used in the adjuvant setting? Yes____ No____

ii. Positive test for *gBRCAm*? Yes____ No____

C. Is diagnosis metastatic breast cancer? Yes____ No____

i. Has member shown progression on previous chemotherapy? Yes____ No____

ii. Is disease hormone receptor (HR)-positive? Yes____ No____

1. Has member failed prior endocrine therapy or considered to not be a candidate for endocrine therapy? Yes____ No____

❑ **Pancreatic Cancer**

A. Is diagnosis metastatic pancreatic adenocarcinoma with known germline BRCA1/BRCA2 mutation? Yes____ No____

B. Will olaparib be used as a single agent for maintenance therapy? Yes____ No____

C. Has member progressed on at least 16 weeks of first-line platinum-based chemotherapy? Yes____ No____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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Criteria

Page 2 of 2– Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization, continued:

1. Please indicate diagnosis and information, continued:

❑ **Prostate Cancer**

A. Is diagnosis metastatic castration-resistant prostate cancer? Yes____ No____
B. Has member failed previous first-line therapy? Yes____ No____
C. Will olaparib be used as a single-agent? Yes____ No____
   i. If no, will olaparib be used with a gonadotropin-releasing hormone (GnRH) analog? Yes____ No____
   ii. If no, does member have a prior history of bilateral orchiectomy? Yes____ No____
D. Is disease positive for a mutation in a homologous recombination gene? 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 olaparib? Yes____ No____
3. Has member experienced adverse drug reactions related to olaparib 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 all pages will result in processing delays.

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