OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Ayvakit™ (Avapritinib) 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

For Initial Authorization:

1. **Please indicate the diagnosis and information:**
   - ❑ **Gastrointestinal Stromal Tumor (GIST)**
     - A. Is diagnosis unresectable or metastatic GIST? Yes____ No____
     - B. Does member have a *PDGFRA* exon 18 mutation (including *PDGFRA* D842V mutations)? Yes____ No____
   - ❑ **Systemic Mastocytosis Diagnosis**
     - A. Is diagnosis advanced systemic mastocytosis? Yes____ No____
       - i. If yes, please select 1 of the following:
         - ___ Aggressive systemic mastocytosis
         - ___ Systemic mastocytosis with an associated hematologic neoplasm
         - ___ Mast cell leukemia
         - ___ Other, please list:_____
     - B. Is member's platelet count ≥50 x 10^9/L? 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 avapritinib? Yes____ No____
3. Has the member experienced adverse drug reactions related to avapritinib 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

CONFIDENTIALITY NOTICE