OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Lytgobi® (Futibatinib) 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:
   - ☐ **Unresectable, locally advanced, or metastatic intrahepatic cholangiocarcinoma**
     a. Was member previously treated with least 1 prior therapy? Yes ☐ No ☐
     b. Is tumor positive for fibroblast growth factor receptor 2 (FGFR2) gene fusion or rearrangement? 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 futibatinib therapy? Yes☐No☐
3. Has member experienced any adverse drug reactions related to futibatinib 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 do not send in chart notes. Specific information will be requested if necessary.*

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