State of Oklahoma
SoonerCare
Retevmo® (Selpercatinib) 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:

☐ **Non-Small Cell Lung Cancer (NSCLC)**
- A. Is diagnosis recurrent, advanced, or metastatic NSCLC? Yes ☐ No ☐
- B. Is tumor rearranged during transfection (RET) fusion positive? Yes ☐ No ☐
- C. Will selpercatinib be used as a single-agent? Yes ☐ No ☐

☐ **Thyroid Cancer**
- A. Will selpercatinib be used as a single-agent? Yes ☐ No ☐
- B. Is disease advanced or metastatic? Yes ☐ No ☐
- C. Is diagnosis RET-mutant medullary thyroid cancer requiring systemic therapy? Yes ☐ No ☐
- D. Is diagnosis RET fusion-positive thyroid cancer? Yes ☐ No ☐
  - i. If yes, does member require systemic therapy? Yes ☐ No ☐
  - ii. Is radioactive iodine appropriate for this member? Yes ☐ No ☐
    - a. If appropriate, is member refractory to radioactive iodine? Yes ☐ No ☐

☐ **Solid Tumor**
- A. Is diagnosis locally advanced or metastatic solid tumor? Yes ☐ No ☐
- B. Is tumor rearranged during transfection (RET) gene fusion? Yes ☐ No ☐
- C. Has disease progressed on or following prior systemic treatment, or are there no satisfactory alternative treatment options? Yes ☐ No ☐
- D. Will selpercatinib be used as a single agent? Yes ☐ No ☐

☐ **If answer is none of the above, please indicate diagnosis:** _____

Additional Information: _____

_____

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

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on selpercatinib? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to selpercatinib therapy? Yes☐ No☐

*If yes, please specify adverse reactions:*_____

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.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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.*