

State of Oklahoma
SoonerCare
Xalkori® (Crizotinib) 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

Provider NPI: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate diagnosis and information:

Non-Small Cell Lung Cancer (NSCLC)

- A. Metastatic NSCLC (first-line or subsequent therapy)? Yes ___ No ___
- B. Is disease anaplastic lymphoma kinase (ALK) or ROS1 positive? Yes ___ No ___
- C. MET amplification? Yes ___ No ___
- D. Will crizotinib be used as a single-agent only? Yes ___ No ___

Soft Tissue Sarcoma

- A. Diagnosis of soft tissue sarcoma—Inflammatory Myofibroblastic Tumor (IMT)? Yes ___ No ___
- B. Is disease ALK positive? Yes ___ No ___
- C. Will crizotinib be used as a single-agent only? Yes ___ No ___

Anaplastic Large Cell Lymphoma (ALCL)

- A. Is disease ALK positive? Yes ___ No ___
- B. Is disease relapsed or refractory? Yes ___ No ___
- C. Will crizotinib be used as a single agent? 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 crizotinib? Yes ___ No ___
- 3. Has the member experienced adverse drug reactions related to crizotinib 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.

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:

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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