OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Imfinzi® (Durvalumab) Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code:_____) Start Date (or date of next dose):_____

Dose:_____ Dosing 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 the diagnosis and information:
   - ☐ **Non-Small Cell Lung Cancer (NSCLC)**
     - A. Does member have unresectable stage II or III NSCLC? Yes☐ No☐
       - i. If yes, has member's disease progressed following concurrent platinum-based chemo-therapy and radiation therapy? Yes☐ No☐
     - B. Does member have metastatic NSCLC? Yes☐ No☐
       - i. If yes, does member have an epidermal growth factor (EGRF) mutation or anaplastic lymphoma kinase (ALK) genomic tumor aberrations? Yes☐ No☐
       - ii. Will durvalumab be used in conjunction with Imjudo® (tremelimumab-actl) and platinum - based chemotherapy? Yes☐ No☐
   - ☐ **Extensive-Stage Small Cell Lung Cancer (ES-SCLC)**
     - A. Will durvalumab be used in combination with etoposide and either cisplatin or carboplatin followed by single-agent maintenance? Yes☐ No☐
   - ☐ **Biliary Tract Cancer**
     - A. Does member have locally advanced or metastatic biliary tract cancer? Yes☐ No☐
     - B. Will durvalumab be used in combination with gemcitabine and cisplatin? Yes☐ No☐
   - ☐ **Hepatocellular Carcinoma (HCC)**
     - A. Does member have a diagnosis of unresectable HCC? Yes☐ No☐
     - B. Will durvalumab be used in combination with Imjudo® (tremelimumab-actl)? Yes☐ No☐
   - ☐ **If diagnosis is not listed above, please indicate diagnosis:**_____

Additional Information: _____

_____

_____

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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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 durvalumab? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to durvalumab 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. *Failure to complete this form in full will result in processing delays.*

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