OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

Jemperli® (dostarlimab-gxly) Prior Authorization Form

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

Drug Information

☐ ***Physician billing (HCPCS code:*** _____***)*** ☐ ***Pharmacy billing (NDC:*** _____***)***

Dose: _____ ***Regimen:*** _____ ***Start Date (or date of next dose):*** _____

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:

1. Please indicate the diagnosis and information:

☐ **Endometrial Cancer**

A. Please indicate how dostarlimab-gxly will be used:

☐ Single agent

i. Is disease advanced, recurrent, or metastatic endometrial cancer? Yes ☐ No ☐

ii. Is disease mismatch repair deficient (dMMR)? Yes ☐ No ☐

iii. Has disease progressed on or following prior treatment with a platinum-containing regimen? Yes ☐ No ☐

☐ In combination with carboplatin and paclitaxel

i. Is disease primary advanced or recurrent endometrial cancer? Yes ☐ No ☐

ii. Is disease mismatch repair deficient (dMMR) or microsatellite instability-high (MSI-H) disease? Yes ☐ No ☐

☐ **Mismatch Repair (dMMR) Solid Tumor**

A. Is disease recurrent or advanced? Yes ☐ No ☐

B. Has disease progressed on or following prior treatment? Yes ☐ No ☐

C. Are there satisfactory treatment alternatives for the member? 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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Criteria

For Continued Authorization:

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

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