OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Loqtorzi™ (Toripalimab-tpzi) 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:
   - ❑ Nasopharyngeal Carcinoma (NPC)
   - ❑ Other: _______________________________
2. Is disease metastatic or recurrent, locally advanced NPC? Yes___ No___
   a. Will toripalimab-tpzi be used in the first-line setting? Yes___ No___
   b. Will toripalimab-tpzi be used in combination with cisplatin and gemcitabine? Yes___ No___
3. Is disease previously treated recurrent unresectable or metastatic NPC? Yes___ No___
   a. Has disease progressed on or following a platinum-containing chemotherapy? Yes___ No___
   b. Will toripalimab-tpzi be used as a single agent? Yes___ No___
   c. Please provide member's weight (kg): ______

Additional Information: ____

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For Continued Authorization:

1. Date of last dose: _______________________________
2. Does member have any evidence of progressive disease while on toripalimab-tpzi? Yes___ No___
3. Has member experienced adverse drug reactions related to toripalimab-tpzi 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 and attach requested clinical notes 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.*