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

Additional Information: _____

**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:

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

CONFIDENTIALITY NOTICE