OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Rubraca® (Rucaparib) 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:**
   - ❑ **Advanced Ovarian, Fallopian Tube, or Primary Peritoneal Cancer**
     - A. Will rucaparib be used as a single-agent? Yes ☐ No ☐
     - B. Will rucaparib be used for **treatment** of recurrent or refractory disease? Yes ☐ No ☐
       - i. If yes, was member previously treated with 2 or more lines of prior chemotherapy? Yes ☐ No ☐
         1. If yes, please provide prior chemotherapy regimens:_____
       - ii. Is disease associated with a deleterious or suspected deleterious BRCA mutation? Yes ☐ No ☐
     - C. Will rucaparib be used for **maintenance treatment** of advanced or recurrent disease? Yes ☐ No ☐
       - i. If yes, is disease in a complete or partial response to platinum-based chemotherapy? Yes ☐ No ☐
   - ❑ **Prostate Cancer**
     - A. Is diagnosis metastatic, castration-resistant prostate cancer? Yes ☐ No ☐
     - B. Has member failed previous first-line therapy? Yes ☐ No ☐
     - C. Will rucaparib be used as a single-agent? Yes ☐ No ☐
       - i. If no, will olaparib be used with a gonadotropin-releasing hormone (GnRH) analog? Yes ☐ No ☐
       - ii. If no, does member have a prior history of bilateral orchiectomy? Yes ☐ No ☐
     - D. Is disease positive for BRCA1 or BRCA2 mutation? Yes ☐ No ☐
   - ❑ **If diagnosis is not listed 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 rucaparib? Yes ☐ No ☐
3. Has the member experienced adverse drug reactions related to rucaparib 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

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