State of Oklahoma
SoonerCare
Zejula® (Niraparib) 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:**

❑ **Ovarian, Fallopian Tube, or Primary Peritoneal Cancer Treatment**

A. Will niraparib be used as a single-agent? Yes ☐ No ☐
B. Is the member's disease recurrent or refractory? Yes ☐ No ☐
C. Has member received previous treatment with 3 or more lines of chemotherapy? Yes ☐ No ☐
   i. If yes, please list the member's prior chemotherapy treatments:
   _____
D. Is the diagnosis homologous recombination deficiency (HRD) positive? Yes ☐ No ☐
   i. If yes, please indicate which of the following is applicable for this member:
   ❑ Deleterious or suspected deleterious BRCA mutation
   ❑ Genomic instability and progression >6 months after response to last platinum-based chemotherapy
E. Will niraparib be used in combination with bevacizumab for platinum-sensitive persistent disease or recurrence? Yes ☐ No ☐
   i. If yes, please indicate which of the following is applicable for this member:
   ❑ Niraparib will be used as immediate treatment for serially rising CA-125 in members that previously received chemotherapy
   ❑ Evidence of radiographic and/or clinical relapse in members with previous complete remission and relapse ≥6 months after completing prior chemotherapy

❑ **Ovarian, Fallopian Tube, or Primary Peritoneal Cancer Maintenance Treatment**

A. Is the member's disease advanced or recurrent? Yes ☐ No ☐
B. Is disease in a complete or partial response to platinum chemotherapy? Yes ☐ No ☐
C. Will niraparib be used as a single-agent? Yes ☐ No ☐

❑ **If diagnosis is none of the above, please indicate diagnosis:** _____

For Continued Authorization:

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