SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Alecensa® (Alectinib) 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

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Diagnosis of non-small cell lung cancer (NSCLC)? Yes____ No____
   A. If answer is 'yes' to question 1, please check all of the following that apply:
      - ☐ Recurrent or metastatic NSCLC
      - ☐ Anaplastic lymphoma kinase (ALK) positivity
      - ☐ Alectinib will be used as a single-agent only
2. If answer is 'no' to question 1, please provide diagnosis:_____

Additional Information:_____
_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on alectinib? Yes____ No____
3. Has the member experienced adverse drug reactions related to alectinib 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.
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