SoonerCare
Oklahoma Health Care Authority

# State of Oklahoma
# Oklahoma Health Care Authority
# Lorbrena® (Lorlatinib) 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:
   - ❑ Metastatic NSCLC
   - ❑ Tumor expresses Anaplastic Lymphoma Kinase (ALK) translocation
   - ❑ Lorlatinib will be used as a single-agent
   - ❑ Lorlatinib will be used as second-line therapy following disease progression on alectinib or ceritinib
   - ❑ Lorlatinib will be used as third-line or greater therapy following disease progression on crizotinib and one other ALK inhibitor (i.e., ceritinib or alectinib)

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 lorlatinib? Yes____ No____
3. Has the member experienced adverse drug reactions related to lorlatinib 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: | CONFIDENTIALITY NOTICE |
|---|---|
| University of Oklahoma College of Pharmacy<br>Pharmacy Management Consultants<br>Product Based Prior Authorization Unit<br><br>Fax: 1-800-224-4014<br>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.* |