SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Talzenna® (Talazoparib) 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:

1. Please indicate diagnosis and information:
   - ❑ **Breast Cancer**
     - A. Metastatic or recurrent breast cancer? Yes ☐ No ☐
     - B. Human epidermal growth factor receptor 2 (HER2)-status? Positive ☐ Negative ☐
     - C. Positive test for BRCA 1/2-germline mutation? Yes ☐ No ☐
     - D. Hormone receptor (HR)-positive? Yes ☐ No ☐
       - i. If yes, has member failed prior endocrine therapy or considered to not be a candidate for endocrine therapy? Yes ☐ No ☐
     - E. Hormone receptor (HR)-negative? Yes ☐ No ☐
     - F. Does member have symptomatic visceral disease? Yes ☐ No ☐
     - G. Will talazoparib be used as a single agent? Yes ☐ No ☐

   - ❑ **Other, please provide diagnosis:** _____

Additional Information: _____

_____

_____

For Continued Authorization:

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