OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Ayvakit™ (Avapritinib) 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:**
   - ❑ **Gastrointestinal Stromal Tumor (GIST)**
     - A. Is diagnosis unresectable or metastatic GIST? Yes☐ No☐
     - B. Does member have a *PDGFRA* exon 18 mutation (including *PDGFRA* D842V mutations)? Yes☐ No☐
   - ❑ **If diagnosis is not GIST, please indicate diagnosis:**_____

Additional Information:_____

_____

For Continued Authorization:

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