

Augtyro™ (repotrectinib) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Pharmacy billing (NDC: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

Pharmacy 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 diagnosis and information:

Non-Small Cell Lung Cancer (NSCLC)

A. Is NSCLC locally advanced or metastatic? Yes No

B. Is NSCLC ROS1-positive? Yes No

C. Will repotrectinib be used as a single agent? Yes No

Other: _____

Additional information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on repotrectinib? Yes No

3. Has member experienced adverse drug reactions related to repotrectinib 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.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma**.

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