OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

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Emrelis™ (telisotuzumab vedotin-tllv) Prior Authorization Form

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

Drug Information

☐ ***Physician billing (HCPCS code: _____)*** ☐ ***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 provide member's diagnosis:

☐ **Non-Small Cell Lung Cancer (NSCLC)**

A. Is diagnosis recurrent, advanced, or metastatic non-squamous NSCLC? Yes☐ No☐
B. Does member have disease with high c-Met/MET protein overexpression, defined as ≥50% of tumor cells with strong staining [immunohistochemistry (IHC) 3+]? Yes☐ No☐
C. Epidermal growth factor receptor (EGFR) wild-type? Yes☐ No☐
D. Has member received prior systemic therapy? Yes☐ No☐
E. Member's ECOG performance status: _____
F. Will Emrelis™ be used as a single agent? Yes☐ No☐
G. Member's weight: _____ (kg)

☐ **Other:** _____

For Continued Authorization:

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

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® 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.	CONFIDENTIALITY NOTICE *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.*