

Ojemda™ (tovorafenib) 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 the diagnosis and information:

Low Grade Glioma (LGG)A. Is diagnosis relapsed or refractory pediatric LGG? Yes No B. Is there a presence of BRAF fusion, BRAF rearrangement, or BRAF V600 mutation?
Yes No

C. Member's body surface area (BSA): _____ Date taken: _____

D. If BSA $\geq 0.90\text{m}^2$ and request is for the oral suspension formulation, please provide a patient-specific, clinically significant reason why the tablet formulation cannot be used: _____ Other _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

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

3. Has the member experienced any adverse drug reactions related to tovorafenib 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 through CoverMyMeds® or SureScripts. All requested data must be provided. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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