SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Lynparza® (Olaparib) 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 (Initial approval will be for the duration of 6 months):

1. Please indicate diagnosis and information:

☐ **Advanced Recurrent/Refractory Ovarian Cancer Treatment**
- A. Presence of deleterious or suspected deleterious germline BRCA mutation (gBRCAm)? Yes ☐ No ☐
- B. Member previously treated with three or more lines of prior chemotherapy? Yes ☐ No ☐
  - i. If yes, please provide prior chemotherapy regimens: _____

☐ **Maintenance Treatment of Advanced Ovarian Cancer**
- A. Is member in complete or partial response to first-line platinum based chemotherapy? Yes ☐ No ☐
  - i. If yes, presence of deleterious or suspected deleterious germline BRCA mutation (gBRCAm)? Yes ☐ No ☐
- B. Is member in complete or partial response to second-line or greater platinum based chemotherapy? Yes ☐ No ☐

☐ **Breast Cancer**
- A. Metastatic breast cancer? Yes ☐ No ☐
- B. Has member shown progression on previous chemotherapy in any setting? Yes ☐ No ☐
- C. Human epidermal growth factor receptor 2 (HER2)-status? Positive ☐ Negative ☐
- D. Positive test for germline BRCA-mutation? Yes ☐ No ☐
- E. 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 ☐

☐ **Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer**
- A. Will olaparib be used for maintenance treatment in recurrent disease where member had a complete or partial response to platinum-based chemotherapy? Yes ☐ No ☐
- B. Has member completed platinum-based therapy in the past 8 weeks? Yes ☐ No ☐

☐ **Other, please provide diagnosis:** _____

For Continued Authorization:

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