

State of Oklahoma
Oklahoma Health Care Authority
Talzenna® (Talazoparib) 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:

1. Please indicate diagnosis and information:

Breast Cancer

- A. Metastatic or recurrent breast cancer? Yes _____ No _____
- B. Human epidermal growth factor receptor 2 (HER2)-status? Positive _____ Negative _____
- C. Positive test for BRCA 1/2-germline mutation? Yes _____ No _____
- D. 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 _____
- E. Hormone receptor (HR)-negative? Yes _____ No _____
- F. Does member have symptomatic visceral disease? Yes _____ No _____
- G. Will talazoparib be used as a single agent? Yes _____ No _____

Other, please provide diagnosis: _____

Additional Information: _____

For Continued Authorization:

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

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