



**State of Oklahoma  
SoonerCare  
Pemazyre® (Pemigatinib) 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**

**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:**

**Cholangiocarcinoma:**

A. Does member have unresectable, locally advanced or metastatic cholangiocarcinoma?

Yes \_\_\_\_\_ No \_\_\_\_\_

B. Has the member failed 1 or more prior therapies? Yes \_\_\_\_\_ No \_\_\_\_\_

C. Is disease positive for a fibroblast growth factor receptor 2 (FGFR2) fusion or other FGFR rearrangement? Yes \_\_\_\_\_ No \_\_\_\_\_

**Myeloid/Lymphoid Neoplasms (MLNs):**

A. Are MLNs relapsed or refractory? Yes \_\_\_\_\_ No \_\_\_\_\_

B. Is disease positive for a fibroblast growth factor receptor 1 (FGFR1) rearrangement? Yes \_\_\_\_\_ No \_\_\_\_\_

**If diagnosis is none of the above, please indicate diagnosis:** \_\_\_\_\_

**Additional Information:** \_\_\_\_\_

**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_

2. Does member have any evidence of progressive disease while on pemigatinib? Yes \_\_\_\_\_ No \_\_\_\_\_

3. Has the member experienced adverse drug reactions related to pemigatinib 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

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