OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Trodelvy™ (Sacituzumab Govitecan-hziy)
Prior Authorization Form

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

Drug Information

❑**Physician billing (HCPCS code:**_____**)** ❑**Pharmacy billing (NDC:**_____**)**

Dose:_____ ***Regimen:***_____ ***Start Date (or date of next dose):***_____

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 the diagnosis and information:**
   - ❑ **Breast Cancer**
     - A. Does the member have a diagnosis of triple-negative breast cancer? Yes☐ No☐
     - B. Does the member have metastatic disease? Yes☐ No☐
     - C. Has the member received 2 or more therapies for metastatic disease? Yes☐ No☐

   - ❑ **If answer 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 sacituzumab govitecan-hziy?
   Yes☐ No☐
3. Has the member experienced adverse drug reactions related to sacituzumab govitecan-hziy 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