

State of Oklahoma  
SoonerCare  
**Qinlock™ (Ripretinib) 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:**

**Gastrointestinal Stromal Tumor (GIST)**

A. Is diagnosis advanced GIST? Yes \_\_\_ No \_\_\_

B. Has member previously received 3 or more kinase inhibitors, including imatinib (Gleevec®)?  
Yes \_\_\_ No \_\_\_

C. Will ripretinib be used as a single-agent? 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 ripretinib? Yes \_\_\_ No \_\_\_

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