

State of Oklahoma SoonerCare Margenza[®] (Margetuximab-cmkb) 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 Please indicate the diagnosis and information: Breast Cancer A. Is disease metastatic? Yes No B. Is disease human epidermal receptor type 2 (HER2)-positive? Yes No C. Has member received 2 or more prior anti-HER2 regimens with at least 1 treatment for metastatic disease? Yes No D. Will margetuximab-cmkb be used in combination with chemotherapy (capecitabine, eribulin, gemcitabine, or vinorelbine)? 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 margetuximab-cmkb ? Yes___ No____
- 3. Has the member experienced adverse drug reactions related to margetuximab-cmkb 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:	CONFIDENTIALITY NOTICE
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