SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Gilotrif® (Afatinib) 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 (Initial approval will be for the duration of 6 months):

1. Please indicate diagnosis and information:
   - ☐ Non-Small Cell Lung Cancer (NSCLC)
     - A. Metastatic NSCLC? Yes____ No____
     - B. Epidermal growth factor receptor (EGFR) mutation detected? Yes____ No____
     - C. Afatinib used in the first-line setting? Yes____ No____
     - D. Afatinib used as a single-agent? Yes____ No____
     - E. Progressed following platinum-based chemotherapy? Yes____ No____
     - F. Afatinib used in combination with cetuximab in patients with a known sensitizing EGFR mutation who are T790M negative? Yes____ No____
   - ☐ Head and Neck Cancer
     - A. Disease progression on or after platinum containing chemotherapy? Yes____ No____
     - B. Non-nasopharyngeal cancer? Yes____ No____
     - C. Newly diagnosed T4b, any N, M0 disease, unresectable nodal disease with no metastases, or member unfit for surgery? Yes____ No____
     - D. Metastatic (M1) disease at initial presentation, recurrent/persistent disease with distant metastases, or unresectable locoregional recurrence or second primary with prior radiation therapy (RT)? Yes____ No____
     - E. Unresectable locoregional recurrence without prior RT? Yes____ No____
     - F. Performance status (PS): _____
     - G. Afatinib 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 afatinib? Yes____ No____
3. Has the member experienced adverse drug reactions related to afatinib 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