OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
Ayvakit™ (Avapritinib) Prior Authorization Form

SoonerSelect | aetna

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 unresectable or metastatic GIST? Yes☐ No☐
     - B. Does member have a *PDGFRA* exon 18 mutation (including *PDGFRA* D842V mutations)? Yes☐ No☐
   - ☐ **Advanced Systemic Mastocytosis (AdvSM) Diagnosis**
     - A. Please select one of the following:
       - ☐ Aggressive systemic mastocytosis
       - ☐ Systemic mastocytosis with an associated hematologic neoplasm
       - ☐ Mast cell leukemia
       - ☐ Other, please list:_____
     - B. Is member's platelet count ≥50 x 10^9/L? Yes☐ No☐
   - ☐ **Indolent Systemic Mastocytosis (ISM) Diagnosis**
     - A. Is member's platelet count ≥50 x 10^9/L? Yes☐ No☐
   - ☐ **If diagnosis is not listed 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 avapritinib? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to avapritinib 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. *Failure to complete this form in full will result in processing delays.*

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**