OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Bavencio® (Avelumab) Prior Authorization Form

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

Drug Information

Physician billing **(HCPCS code:**_____**)** ***Start Date*** **(or date of next dose):**_____

Dose:_____ ***Regimen:***_____

Billing Provider Information

SoonerCare Provider ID:_____ ***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 provide member's most recent weight (kg): _____ Date Determined: _____
2. Please indicate the diagnosis and information:
   - ❑ **Merkel Cell Carcinoma (MCC)**
     - A. Is diagnosis metastatic MCC? Yes☐ No☐
   - ❑ **Urothelial Carcinoma**
     - A. Is diagnosis locally advanced or metastatic urothelial carcinoma? Yes☐ No☐
     - B. Has disease progressed during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy? Yes☐ No☐
     - C. Will avelumab be used as maintenance therapy? Yes☐ No☐
     - D. Has disease progressed on a first-line platinum-containing regimen? Yes☐ No☐
   - ❑ **Renal Cell Carcinoma (RCC)**
     - A. Is diagnosis advanced RCC? Yes☐ No☐
     - B. Will avelumab be used as first-line treatment? Yes☐ No☐
     - C. Will avelumab be used in combination with axitinib? Yes☐ No☐
   - ❑ **If diagnosis is not listed above, please provide diagnosis:**_____

Additional Information:_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on avelumab? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to avelumab 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.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® 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.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*