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State of Oklahoma
Oklahoma Health Care Authority

Halaven® (Eribulin) 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 indicate the diagnosis and information:
   - ❑ **Recurrent or Metastatic Breast Cancer**
     - A. Has the member previously received at least 2 chemotherapy regimens for the treatment of metastatic disease? Yes ☐ No ☐
     - B. Did prior therapy include an anthracycline and a taxane in either the adjuvant or metastatic setting? Yes ☐ No ☐
     - C. Please provide dates/dose/duration of previous treatment:_____
       _____
     - D. Please indicate the following:
       ☐ Hormone receptor-negative ☐ Hormone receptor-positive
     - E. Will eribulin be used in combination with trastuzumab in Human Epidermal Receptor Type 2 (HER2)-Positive disease? Yes ☐ No ☐
       - i. If disease is hormone receptor-positive will eribulin be used with endocrine therapy? Yes ☐ No ☐
     - F. Will eribulin be used a single-agent in HER2-Negative disease? Yes ☐ No ☐
       - i. If disease is hormone receptor-positive, please indicate the following:
         ☐ Visceral Crisis ☐ Endocrine Therapy Refractory ☐ Other:_____
   - ❑ **Unresectable or Metastatic Liposarcoma**
     - A. Has the member previously received an anthracycline-containing chemotherapy regimen? Yes ☐ No ☐
     - B. Please provide dates/dose/duration of previous treatment: _____
       _____
   - ❑ **If answer is none of the above, please indicate diagnosis:**_____
2. Please provide member's body surface area (m^2): _____

For Continued Authorization:

1. Does member have any evidence of progressive disease while on eribulin? Yes ☐ No ☐
2. Has the member experienced adverse drug reactions related to eribulin 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 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.**	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.*