OKLAHOMA Health Care Authority

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State of Oklahoma SoonerCare Lenvima® (Lenvatinib) 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

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:

- ☐ **Endometrial Carcinoma**
  - A. Is disease advanced with progression on prior systemic therapy? Yes☐ No☐
  - B. Is member a candidate for curative surgery or radiation? Yes☐ No☐
  - C. Is disease mismatch repair proficient (pMMR)? Yes☐ No☐
  - D. Is disease microsatellite instability-high (MSI-H)? Yes☐ No☐
  - E. Will lenvatinib be used in combination with pembrolizumab? Yes☐ No☐
- ☐ **Hepatocellular Carcinoma (HCC)**
  - A. Is disease unresectable? Yes☐ No☐
  - B. Will lenvatinib be used as first-line treatment? Yes☐ No☐
- ☐ **Renal Cell Carcinoma (RCC)**
  - A. Is disease advanced? Yes☐ No☐
  - B. Will lenvatinib be used in combination with pembrolizumab? Yes☐ No☐
  - C. Will lenvatinib be used following 1 prior anti-angiogenic therapy? Yes☐ No☐
    - i. If yes, will lenvatinib be used in combination with everolimus? Yes☐ No☐
- ☐ **Differentiated Thyroid Cancer (DTC)**
  - A. Is disease locally recurrent or metastatic? Yes☐ No☐
  - B. Has disease progressed on prior treatment? Yes☐ No☐
  - C. Is disease radioactive iodine-refractory? Yes☐ No☐
- ☐ **If diagnosis is not listed above, please indicate diagnosis:**______________________________

For Continued Authorization:

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

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