OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

SoonerSelect | aetna

# Tazverik® (Tazemetostat) 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:
   - ❑ **Epithelioid Sarcoma**
     - A. Is disease metastatic or locally advanced? Yes ☐ No ☐
     - B. Is member eligible for complete resection? Yes ☐ No ☐
   - ❑ **Follicular Lymphoma (FL)**
     - A. Is disease relapsed or refractory? Yes ☐ No ☐
     - B. EZH2 detected mutation? Yes ☐ No ☐
     - C. Has member received at least 2 lines of therapy? Yes ☐ No ☐
     - D. Will tazemetostat be used as subsequent therapy where there are no satisfactory alternative treatment options? Yes ☐ No ☐
   - ❑ **If answer is none of the above, please indicate diagnosis:** __________________________________

Additional Information: __________________________________________________________________________

### For Continued Authorization:

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

*If yes, please specify adverse reactions:* __________________________________________________________

Additional Information: _________________________________________________________________________

**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.** | <u>CONFIDENTIALITY NOTICE</u><br>*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.* |
|---|---|