State of Oklahoma SoonerCare
Zejula® (Niraparib) Prior Authorization Form

OKLAHOMA Health Care Authority | SoonerSelect | aetna

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

Drug Information

Pharmacy Billing (NDC: _____***) Start Date (or date of next dose):*** _____

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

Pharmacy 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:**

☐ **Ovarian, Fallopian Tube, or Primary Peritoneal Cancer Maintenance Treatment**

A. Is the member's disease advanced or recurrent? Yes☐ No☐
B. Is disease in a complete or partial response to platinum chemotherapy? Yes☐ No☐
C. Is niraparib being used for maintenance following recurrence? Yes☐ No☐
   i. If yes, is disease positive for a BRCA mutation? Yes☐ No☐
D. Will niraparib be used as a single-agent? Yes☐ No☐

☐ **If diagnosis is none of the 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 niraparib? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to niraparib 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.*