Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial Individual (Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Lynparza® (olaparib)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☒ Lynparza 100 mg tablet ☒ Lynparza 150 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for Lynparza is $115.72 for each tablet. The annual cost of treatment with this drug is more than $160,000.

Oral oncology partial fill program

Each fill of Lynparza is limited to a 14 day supply at any network pharmacy. Patients are responsible for applicable deductible and copayments.

Precertification Requirements

Before this drug is covered, the patient must meet one of the following requirements:

1. Diagnosis of advanced ovarian cancer
    a. Results of an FDA-approved test must be submitted showing deleterious or suspected deleterious germline BRCA mutated disease
    b. Must have first tried 3 prior treatments

2. Diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer (for maintenance treatment with Lynparza tablets only)
    a. Must have first tried at least 2 prior platinum-based chemotherapy regimens, with an objective response (complete or partial response) to the most recent.
3. Diagnosis of HER2-negative Metastatic breast cancer in patients with deleterious or suspected deleterious germline BRCA-mutated disease.

All fields must be complete and legible for review. Your office will receive a response via fax.

Created 01/2019
No changes made since 01/2019
Last reviewed 03/2019

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Advanced ovarian cancer
- ☐ Recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer
- ☐ HER2-negative, metastatic breast cancer
- ☐ *Other – the patient's condition is:* _____

B. What prior treatments has the patient used?

Drug/Drug regimen: _____

Drug/Drug regimen: _____

Drug/Drug regimen: _____

Drug/Drug regimen: _____

C. Fax a copy of the FDA-approved test results showing deleterious or suspected deleterious germline BRCA mutated disease with this request, if indicated in precertification requirements for diagnosis.

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