Lorbrena (Iorlatinib) Prior Authorization Request Form

Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

			URGENT	
MEMBER INFORMATION				
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:		
STREET ADDRESS:				
CITY:		STATE: ZIP CODE:		
PATIENT INSURANCE ID NUM	ИBER:			
IF YOU ARE NOT THE PATIENT OR THE PRESCRIFOLLOWING LINK: PRIMETHERAPEUTICS.COM,		OSURE AUTHORIZATION FORM WITH THIS REQU	UEST WHICH CAN BE FOUND AT THE	
PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):				
PRESCRIBER INFORMATION				
LAST NAME:		FIRST NAME:		
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:		
NPI NUMBER:		DEA NUMBER:		
PHONE NUMBER:		FAX NUMBER:		
STREET ADDRESS:				
CITY:		STATE: ZIP CODE:		
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:		
MEDICATION OR MEDICAL DISPENSING INFORMATION				
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
□ NEW THERAPY	RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:		
DURATION OF THERAPY (SPE	CIFIC DATES):			

Continued on next page.



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MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?		YES (if yes, complete below) 🔲 NO
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
☐ Metastatic non-small cell lung cancer (NS	CCLC)	
□ Other diagnosis:	ICD-10:	
3. REQUIRED CLINICAL INFORMATION: PRIOR AUTHORIZATION.	PLEASE PROVIDE ALL RELEVANT CLINICA	AL INFORMATION TO SUPPORT A
Clinical Information:		
Is the tumor positive for an anaplastic test? Yes No (please submit docume)	lymphoma kinase (ALK) rearrangement	, as confirmed by an FDA approved
Has the patient tried and failed crizotion	nib? □ Yes □ No	
Has the patient tried and failed either	alectinib OR ceritinib? □ Yes □ No	
Renewal: Does patient continues to demonstrat	e a positive clinical response? \square Yes \square N	o (please submit documentation)
Are there any other comments, diagno physician feels is important to this rev	oses, symptoms, medications tried or fa iew?	iled, and/or any other information the
information is received.	are covered on all plans. This request ma	
the Health Plan, insurer, Medical Group	provided is true and accurate to the be or its designees may perform a routine uracy of the information reported on thi	audit and request the medical
Prescriber Signature or Electronic I.D.	Verification:	Date:
	ompanying this transmission contain confidential	

FAX THIS FORM TO: 800-424-7640

of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX)

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811



and arrange for the return or destruction of these documents.