Lynparza (olaparib)
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 NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

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 (SPECIFIC 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 castration-resistant prostate cancer □ HER2-negative,high-risk breast cancer □ Epithelial ovarian, fallopian tube, or primary peritoneal cancer □ Other diagnosis: _____ICD-10: _____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient using drug as part of a clinical trial? □ **Yes** □ **No**

For <u>metastatic castration-resistant prostate cancer</u>, please answer the following:

Does patient's cancer have one of the following deleterious or suspected deleterious germline or somatic mutations for homologous recombination repair (HRR): BRCA1, BRCA2, ATM, *BARD1, BRIP1, CDK12, CHEK1, CHEK2, FANCL, PALB2, RAD51B, RAD51C, RAD51D, OR RAD54L*? □ **Yes** □ **No**
***Please submit tumor genetic report*.**

Did patient experience disease progression on prior treatment with enzalutamide (Xtandi)? □ **Yes** □ **No**
Please submit chart notes.

Did patient experience disease progression on prior treatment with abiraterone (Zytiga)? □ **Yes** □ **No**
Please submit chart notes.

Has the patient received prior treatment with mitoxantrone OR cyclophosphamide OR platinum-based chemotherapy OR another PARP inhibitor? □ **Yes** □ **No**

For <u>HER2-negative high-risk, early breast cancer</u>, please answer the following:
Does patient have HER2-negative high-risk, early breast cancer? □ **Yes** □ **No** ***Please submit chart notes.***

Does patient have deleterious or suspected germline BRCA mutation? □ **Yes** □ **No** ***Please submit chart notes.***

Does patient have tumor negative breast cancer (TNBC) [defined as ER and PgR negative (less than IHC nuclear staining <1% AND HER2 negative (defined as not eligible for anti-HER2 therapy)]? □ **Yes** □ **No**
Please submit chart notes.

Has patient been previously treated with adjuvant chemotherapy? □ **Yes** □ **No** ***Please submit chart notes.***

IF patient received adjuvant chemotherapy, and is a TNBC patient, does patient have an axillary node positive (≥ 1 node)? □ **Yes** □ **No** ***Please submit chart notes.***

IF patient received adjuvant chemotherapy, and is a TNBC patient, does patient have an axillary node negative with at least 4 pathologically confirmed positive lymph nodes? □ Yes □ No *Please submit chart notes.*

Has patient been previously treated with neoadjuvant chemotherapy? □ Yes □ No *Please submit chart notes.*

If patient has received neoadjuvant chemotherapy AND patient is tumor negative breast cancer (TNBC), does patient have residual breast cancer in the breast or lymph nodes? □ Yes □ No *Please submit chart notes.*

If patient is ER and/or PR positive and HER2- negative, does patient have residual invasive breast cancer in the resected lymph node(s)? □ Yes □ No *Please submit chart notes.*

Has patient had at least 6 cycles containing anthracyclines, taxanes or both? □ Yes □ No *Please submit chart notes.*

For Epithelial Ovarian, Fallopian Tube and/or Primary Peritoneal Cancer, please answer the following:
Does patient have a diagnosis of deleterious or suspected deleterious germline or somatic *BRCA*-mutated advanced or recurrent stage III or IV epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer? □ Yes □ No *Please submit chart notes.*

Did patient have a complete or partial response to a first-line platinum-based chemotherapy? □ Yes □ No *Please submit chart notes.*

Does patient have early stage disease(I, IIA, IIB or IIC)? □ Yes □ No *Please submit chart notes.*

Has patient been previously treated with another PARP inhibitor such as olaparib/Lynparza®, niraparib/Zejula®, rucaparib/Rubraca®, talazoparib/Talzenna®) for epithelial ovarian, fallopian tube or primary peritoneal cancer? □ Yes □ No *Please submit chart notes.*

Is patient's cancer associated with homologous recombination deficiency (HRD)-positive status defined by either: • a deleterious or suspected deleterious BRCA mutation, and/or • genomic instability? □ Yes □ No *Please submit chart notes.*

Is cancer at Stage IIIB, IIIC or IV? □ Yes □ No *Please submit chart notes.*

Has patient received at least 3 cycles prior with bevacizumab in combination with the last 3 cycles of platinum-based chemotherapy? □ Yes □ No *Please submit chart notes.*

Did patient have debulking surgery*?* □ Yes □ No *Please submit chart notes.*

If Yes to debulking surgery, has patient had at least 2 cycles of bevacizumab in combination with the last 3 cycles of platinum-based chemotherapy? □ Yes □ No *Please submit chart notes.*

Does patient have non-epithelial origin of the ovary, fallopian tube or the peritoneum(i.e. germ cell tumors)? □ Yes □ No *Please submit chart notes.*

Is patient's tumor of low malignant potential or mucinous carcinoma? □ Yes □ No *Please submit chart notes.*

Does patient have synchronous primary endometrial cancer? □ Yes □ No *Please submit chart notes.*

If Yes to above question for synchronous primary endometrial cancer, is patient Stage <II ? □ **Yes** □ **No** ***Please submit chart notes.***

If Yes to above question for synchronous primary endometrial cancer, was patient less than 60 years of age at the time of diagnosis of endometrial cancer with Stage IA or IB grade 1 or 2, or stage IA grade 3 endometriod adenocarcinoma OR ≥60years at the time of diagnosis of endometrial cancer with stage IA grade 1 or 2 endometriod adenocarcinoma? □ **Yes** □ **No** ***Please submit chart notes.***

Does patient have serous or clear cell adenocarcinoma or carcinosarcoma of the endometrium? □ **Yes** □ **No** ***Please submit chart notes.***

Has patient received any previous treatment with a PARP inhibitor (such as olaparib/Lynparza®, niraparib/Zejula®, rucaparib/Rubraca®, talazoparib/Talzenna®) for epithelial ovarian, fallopian tube or primary peritoneal cancer? □ **Yes** □ **No** ***Please submit chart notes.***

Wil patient use bevacizumab in combination with Lynparza(Olaparib)? □ **Yes** □ **No** ***Please submit chart notes.***

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811