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 ☐ 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.***

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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

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

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