Rubraca (rucaparib)
Prior Authorization Request Form

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

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

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):			

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Revision Date: 01/15/2023

Prime THERAPEUTICS™

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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:**
□ Deleterious BRCA1 or BRCA2 gene mutated advanced ovarian cancer □ Deleterious BRCA1 or BRCA2 gene mutated fallopian tube cancer □ Deleterious BRCA1 or BRCA2 gene mutated primary peritoneal cancer □ Deleterious BRCA1 or BRCA2 gene mutated metastatic castration-resistant prostate cancer □ Other diagnosis: _____ICD-10: _____ *Lab documentation of BRCA mutation must be submitted.	

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

Clinical Information:
Will patient be using drug in conjunction with a clinical trial? □ Yes □ No

For <u>recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in complete or partial response to platinum-based chemotherapy</u>, answer the following:

Does the patient have a high grade (grade 2 or 3) serous or endometrioid epithelial ovarian, fallopian tube, or primary peritoneal cancer? □ Yes □ No

How many platinum-based regimens has the patient received? _____

Was the most recent platinum-based regimen a chemotherapy doublet? □ Yes □ No

How many cycles of platinum chemotherapy has the patient received? _____
Please provide the date of the last dose: _____

Is the patient currently in a complete <u>OR</u> partial response to platinum-based chemotherapy as defined by RECIST criteria? □ Yes □ No

Have any other anticancer MAINTENANCE treatments been adminestered in the interval perdio between completion of the most recent platinum-based therapy and initiation of Rubraca? □ Yes □ No

If the patient is a <u>PARTIAL RESPONSDER</u> to platinum therapy, what is their CA-125 level? _____

Has the patient received prior treatment with any PARP inhibitors (ie olaparib/Lynparza, niraparib/Zejula, rucaparib/Rubraca) to date? □ Yes □ No

Has the patient required drainage of ascites during the final TWO cycles of the lsat platinum-based reigmen?
□ Yes □ No

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Does the patient have sympotamic and/or untreated CNS metastases? □ **Yes** □ **No**

For metastatic castration-resistant prostate cancer, answer the following:

Does patient's cancer have a deleterious mutation in BRCA1 or BRCA2? □ **Yes** □ **No**

Please submit tumor genetic report.

Has the patient experienced disease progression after having received at least 1 but no more than 2 androgen-receptor targeted therapies? □ **Yes** □ **No** ***Please submit chart documentation.***

Has the patient experienced disease progression after having received 1 prior taxane-based chemotherapy? □ **Yes** □ **No** ***Please submit chart documentation.***

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

Renewal Request:

Is patient continuing to exhibit a positive clinical response? □ **Yes** □ **No Please provide documentation.**

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

Revision Date: 01/15/2023