

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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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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:**

<input type="checkbox"/> Deleterious <i>BRCA1</i> or <i>BRCA2</i> gene mutated advanced ovarian cancer <input type="checkbox"/> Deleterious <i>BRCA1</i> or <i>BRCA2</i> gene mutated fallopian tube cancer <input type="checkbox"/> Deleterious <i>BRCA1</i> or <i>BRCA2</i> gene mutated primary peritoneal cancer <input type="checkbox"/> Deleterious <i>BRCA1</i> or <i>BRCA2</i> gene mutated metastatic castration-resistant prostate cancer <input type="checkbox"/> <i>ATM</i> mutated metastatic castration-resistant prostate cancer <input type="checkbox"/> Other diagnosis: _____ ICD-10: _____ *Lab documentation of <i>BRCA</i> or <i>ATM</i> mutation must be submitted.	
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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 recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in complete or partial response to platinum-based chemotherapy, 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 OR partial response to platinum-based chemotherapy as defined by RECIST criteria? Yes No

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

If the patient is a PARTIAL RESPONSDER 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 last platinum-based regimen?
 Yes No

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Does the patient have symptomatic 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.*

Does patient's cancer have an ATM mutation? 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 experienced disease progression after having received at least 1 androgen-receptor targeted therapies? Yes No *Please submit chart documentation.*

Has the patient had prior chemotherapy in the castration-resistant setting? Yes No *Please submit chart documentation*

Did the patient have prior taxane chemotherapy for castration-sensitive disease? 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:** _____

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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