



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations. Visit go.covermymeds.com/OptumRx to begin using this free service. Please note: All information below is required to process this request. Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Tagrisso® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Non-small cell lung cancer (NSCLC)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

<p>Clinical Information:</p> <p>Is this request for continuation of prior Tagrisso therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient used Tagrisso within the past 120 days? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have metastatic or recurrent disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is Tagrisso prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select if the patient has tumors that are positive for the following epidermal growth factor receptor (EGFR) mutations:</p> <p><input type="checkbox"/> Exon 19 deletions <input type="checkbox"/> Exon 21 L858R mutations <input type="checkbox"/> T790M mutation <input type="checkbox"/> Sensitizing EGFR mutation</p> <p>Has the patient experienced disease progression (trial and failure) on or after one of the following EGFR tyrosine kinase inhibitors (TKIs): Gilotrif (afatinib), Iressa (gefitinib), Tarceva (erlotinib)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have contraindication or intolerance to at least one prior EGFR tyrosine kinase inhibitor (TKI) therapy [e.g., Gilotrif (afatinib), Iressa (gefitinib), Tarceva (erlotinib)]? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select the intent of treatment:</p> <p><input type="checkbox"/> Used as first-line therapy <input type="checkbox"/> Used as subsequent therapy for disease that has progressed while on Tagrisso therapy</p>
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<p>Quantity Limit Requests:</p> <p>What is the quantity requested per DAY? _____</p> <p>What is the reason for exceeding the plan limitations?</p> <p><input type="checkbox"/> Titration or loading-dose purposes</p> <p><input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)</p> <p><input type="checkbox"/> Requested strength/dose is not commercially available</p> <p><input type="checkbox"/> There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. Please specify: _____</p> <p><input type="checkbox"/> Other: _____</p>
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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: This request may be denied unless all required information is received. If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.** Office use only: Tagrisso_CMS_2019Feb-W