OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Trodelvy® (Sacituzumab Govitecan-hziy) Prior Authorization Form

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

☐ ***Physician billing (HCPCS code:*** _____***)*** ☐ ***Pharmacy billing (NDC:*** _____***)***

Dose:_____ ***Regimen:***_____ ***Start Date (or date of next dose):***_____

Billing Provider Information

Provider NPI:_____ ***Provider Name:***_____

Provider Phone:_____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Criteria

For Initial Authorization

1. **Please indicate the diagnosis and information:**

☐ **Breast Cancer**

A. Does the member have a diagnosis of triple-negative breast cancer? Yes☐ No☐
   i. Does the member have unresectable locally advanced or metastatic disease? Yes☐ No☐
   ii. Has the member received 2 or more prior therapies, at least 1 of which was for metastatic disease? Yes☐ No☐

B. Does the member have a diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer? Yes☐ No☐
   i. Does the member have unresectable locally advanced or metastatic disease? Yes☐ No☐
   ii. Has the member received endocrine-based therapy and ≥2 additional systemic therapies in the metastatic setting? Yes☐ No☐

☐ **Urothelial Cancer**

A. Does the member have unresectable, locally advanced or metastatic disease? Yes☐ No☐
B. Has the member previously received a platinum-containing chemotherapy? Yes☐ No☐
C. Has the member previously received a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor ? Yes☐ No☐

☐ **If answer is none of the above, please indicate diagnosis:**_____

Additional Information:_____

_____

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.
All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**

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Member Name:_____ Date of Birth:_____ Member ID#:_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on sacituzumab govitecan-hziy? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to sacituzumab govitecan-hziy therapy? Yes☐ No☐
   If yes, please specify adverse reactions:_____

_____

Additional information: _____

_____

_____

_____

Please complete and return all pages. Failure to complete all pages will result in processing delays.

Prescriber Signature:_____ Date:_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**