

State of Oklahoma
Oklahoma Health Care Authority
Alecensa[®] (Alectinib) Prior Authorization Form



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

Drug Information

Pharmacy billing (NDC: _____) Start Date (or date of next dose): _____
Dose: _____ Regimen: _____

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 (Initial approval will be for the duration of 6 months):

1. Diagnosis of non-small cell lung cancer (NSCLC)? Yes ___ No ___
A. If answer is 'yes' to question 1, please check all of the following that apply:
 - Recurrent or metastatic NSCLC
 - Anaplastic lymphoma kinase (ALK) positivity
 - Alectinib will be used as a single-agent only
2. If answer is 'no' to question 1, please provide diagnosis: _____

Additional Information: _____

For Continued Authorization:

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

Additional Information: _____

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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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.