State of Oklahoma
SoonerCare

Lorbrena® (Lorlatinib) 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:**
   - ❑ Metastatic NSCLC
   - ❑ Tumor expresses Anaplastic Lymphoma Kinase (ALK) translocation
   - ❑ Lorlatinib will be used as a single-agent
   - ❑ Lorlatinib will be used as first-line therapy
   - ❑ Lorlatinib will be used as second-line therapy following disease progression on alectinib or ceritinib
   - ❑ Lorlatinib will be used as third-line or greater therapy following disease progression on crizotinib and 1 other ALK inhibitor (i.e., ceritinib or alectinib)

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 lorlatinib? Yes ☐ No ☐
3. Has the member experienced adverse drug reactions related to lorlatinib 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.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® 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.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*