

Rybrevant® (Amivantamab-vmjw) Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code: _____) 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:

1. Please indicate the diagnosis and information:

Non-Small Cell Lung Cancer (NSCLC)

A. Is disease locally advanced or metastatic? Yes ___ No ___

B. Does tumor exhibit epidermal growth factor receptor (EGFR) exon 20 insertion mutations?
Yes ___ No ___

C. Has disease progressed on or after platinum-based chemotherapy? Yes ___ No ___

D. Will Rybrevant® be used as a single agent? Yes ___ No ___

If diagnosis is not listed above, please indicate diagnosis: _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does the member have any evidence of progressive disease while on amivantamab-vmjw?

Yes ___ No ___

3. Has the member experienced any adverse drug reactions related to amivantamab-vmjw 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. 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 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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