SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Halaven® (Eribulin) Prior Authorization Form

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

Drug Information

☐ Physician billing (HCPCS code:_____)

Dose: _____ ***Regimen:*** _____ ***Start Date:*** _____

Billing Provider Information

SoonerCare Provider ID: _____ ***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. Please indicate the diagnosis and information:
   - ☐ Metastatic breast cancer
     - A. Has the member previously received at least 2 chemotherapy regimens for the treatment of metastatic disease? Yes ___ No___
     - B. Did prior therapy include an anthracycline and a taxane in either the adjuvant or metastatic setting? Yes ___ No___
     - C. Please provide dates/dose/duration of previous treatment: _____

_____

   - ☐ Unresectable or metastatic liposarcoma
     - A. Has the member previously received an anthracycline-containing chemotherapy regimen? Yes ___ No___
     - B. Please provide dates/dose/duration of previous treatment: _____

_____

   - ☐ If answer is none of the above, please indicate diagnosis:_____
2. Please provide member's body surface area (m^2): _____

Additional Information: _____

_____

For Continued Authorization:

1. Does member have any evidence of progressive disease while on eribulin?
   Yes____ No____
2. Has the member experienced adverse drug reactions related to eribulin therapy?
   Yes____ No____

*If yes, please specify adverse reactions:*_____

_____

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.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*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.*