

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

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:

Recurrent or 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: _____
- D. Please indicate the following:
 Hormone receptor-negative Hormone receptor-positive
- E. Will eribulin be used in combination with trastuzumab in Human Epidermal Receptor Type 2 (HER2)-Positive disease? Yes ___ No ___
i. If disease is hormone receptor-positive will eribulin be used with endocrine therapy? Yes ___ No ___
- F. Will eribulin be used a single-agent in HER2-Negative disease? Yes ___ No ___
i. If disease is hormone receptor-positive, please indicate the following:
 Visceral Crisis Endocrine Therapy Refractory Other: _____

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 (m²): _____

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:

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

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