

State of Oklahoma  
Oklahoma Health Care Authority  
**Gilotrif® (Afatinib) 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. Please indicate diagnosis and information:

- Non-Small Cell Lung Cancer (NSCLC)
  - A. Metastatic NSCLC? Yes \_\_\_ No \_\_\_
  - B. Epidermal growth factor receptor (EGFR) mutation detected? Yes \_\_\_ No \_\_\_
  - C. Afatinib used in the first-line setting? Yes \_\_\_ No \_\_\_
  - D. Afatinib used as a single-agent? Yes \_\_\_ No \_\_\_
  - E. Progressed following platinum-based chemotherapy? Yes \_\_\_ No \_\_\_
  - F. Afatinib used in combination with cetuximab in patients with a known sensitizing EGFR mutation who are T790M negative? Yes \_\_\_ No \_\_\_
- Head and Neck Cancer
  - A. Disease progression on or after platinum containing chemotherapy? Yes \_\_\_ No \_\_\_
  - B. Non-nasopharyngeal cancer? Yes \_\_\_ No \_\_\_
  - C. Newly diagnosed T4b, any N, M0 disease, unresectable nodal disease with no metastases, or member unfit for surgery? Yes \_\_\_ No \_\_\_
  - D. Metastatic (M1) disease at initial presentation, recurrent/persistent disease with distant metastases, or unresectable locoregional recurrence or second primary with prior radiation therapy (RT)? Yes \_\_\_ No \_\_\_
  - E. Unresectable locoregional recurrence without prior RT? Yes \_\_\_ No \_\_\_
  - F. Performance status (PS): \_\_\_\_\_
  - G. Afatinib used as a single-agent? Yes \_\_\_ No \_\_\_
- Other, please provide diagnosis: \_\_\_\_\_

Additional Information: \_\_\_\_\_

**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_
2. Does member have any evidence of progressive disease while on afatinib? Yes \_\_\_ No \_\_\_
3. Has the member experienced adverse drug reactions related to afatinib 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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