

State of Oklahoma  
Oklahoma Health Care Authority  
**Zykadia® (Ceritinib) 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. Anaplastic lymphoma kinase (ALK) positivity? Yes \_\_\_ No \_\_\_
    - C. Ceritinib used as a single-agent? Yes \_\_\_ No \_\_\_
  - Soft Tissue Sarcoma-Inflammatory Myofibroblastic Tumor (IMT)
    - A. Anaplastic lymphoma kinase (ALK) positivity? Yes \_\_\_ No \_\_\_
    - B. Ceritinib 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 ceritinib? Yes \_\_\_ No \_\_\_
3. Has the member experienced adverse drug reactions related to ceritinib 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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