Rozlytrek (entrectinib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	**DURATION OF THERAPY** (SPECIFY DATES):	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Non-small cell lung cancer ☐ Locally advanced or metastatic solid tumor ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is drug going to be used as part of a clinical trial?

Does the patient have metastatic non-small cell lung cancer (NSCLC)? ☐ **Yes** ☐ **No** ***Please submit documentation***

Does the patient have a metastatic solid tumor? ☐ **Yes** ☐ **No** ***Please submit documentation***

Does the patient have a a locally advanced solid tumor for which surgical resection would likely result in severe morbidity? ☐ **Yes** ☐ **No** ***Please submit documentation***

Is the patient's tumor positive for a NTRK1, NTRK2, and/or NTRK3 gene fusion?
☐ ***Yes*** ☐ ***No*** ***Please submit documentation***

Is the patient's tumor positive for a ROS-1 mutation? ☐ ***Yes*** ☐ ***No*** ***Please submit documentation***

Is the patient Eastern Cooperative Oncology Group (ECOG) performance status of 0, 1 or 2 (is ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours)?
☐ **Yes** ☐ **No**

If requesting Rozyltrek Pellets(entrectinib pellets),please answer the following:

Does patient have an enteral feeding tube ? ☐ ***Yes*** ☐ ***No*** ***Please submit documentation***

Does patient have difficulty swallowing? ☐ ***Yes*** ☐ ***No*** ***Please submit documentation***

Does patient does not have other oral tablets or capsules* on their claims profile in the proceeding four months ? (*however, sprinkles capsules are also OK) ☐ ***Yes*** ☐ ***No*** ***Please submit documentation***

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

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***Please note:** Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.
ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form. **Prescriber Signature or Electronic I.D. Verification:** _____ **Date:** _____
CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in re liance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediate ly (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811