

Lynparza (olaparib) 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 NUN	MBER:			
_			ERGIES:	
F 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				
	ESENTATIVE (IF APPLICABLE): 'E'S PHONE NUMBER:			
DDECCRIPED INFORMATION				
PRESCRIBER INFORMATION LAST NAME:		FIDET NAME.		
LAST NAIVIE:		FIRST NAME:		
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:		
NPI NUMBER:		DEA NUMBER:		
PHONE NUMBER:		FAX NUMBER:		
STREET ADDRESS:				
CITY:		STATE: ZIP CC	DDE:	
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:		
MEDICATION OR MEDICAL I	DISPENSING INFORMATION			
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
NEW THERAPY DURATION OF THERAPY (SPE	RENEWAL CIFIC DATES):	IF RENEWAL: DATE THEF	RAPY INITIATED:	

Continued on next page.



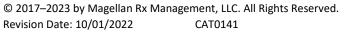


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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:		
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO	
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:	
2. LIST DIAGNOSES:		ICD-10:	
□ Metastatic castration-resistant prostate of HER2-negative, high-risk breast cancer	cancer		
□ Other diagnosis:	ICD-10:		
	: PLEASE PROVIDE ALL RELEVANT CLINICA	AL INFORMATION TO SUPPORT A	
Is patient using drug as part of a clinical	al trial? 🗆 Yes 🗆 No		
mutations for homologous recombinate FANCL, PALB2, RAD51B, RAD51C, RAD51B, Please submit tumor genetic report. Did patient experience disease progress Please submit chart notes.	following deleterious or suspected deletion repair (HRR): BRCA1, BRCA2, ATM, 51D, OR RAD54L? ssion on prior treatment with enzalutar ssion on prior treatment with abiratero	BARD1, BRIP1, CDK12, CHEK1, CHEK2, mide (Xtandi)?	
Has the patient received prior treatme chemotherapy OR another PARP inhib	ent with mitoxantrone OR cyclophospha itor? Yes No	nmide OR platinum-based	
	ast cancer, please answer the following risk, early breast cancer? Yes No		
Does patient have deleterious or suspe	ected germline BRCA mutation? Yes	□ No Please submit chart notes.	
•	ast cancer (TNBC) [defined as ER and Pg ned as not eligible for anti-HER2 therap		
Has patient been previously treated w	ith adjuvant chemotherapy? \square Yes \square N	lo Please submit chart notes.	
IF patient received adjuvant chemother node)? □ Yes □ No Please submit ch	erapy, and is a TNBC patient, does patie art notes.	nt have an axillary node positive (≥ 1	









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IF patient received adjuvant chemotherapy, and is a TNBC patient, does patient have an axillary node negative with at least 4 pathologically confirmed positive lymph nodes? Yes No Please submit chart notes.
Has patient been previously treated with neoadjuvant chemotherapy? ☐ Yes ☐ No Please submit chart notes.
If patient has received neoadjuvant chemotherapy AND patient is tumor negative breast cancer (TNBC), does patient have residual breast cancer in the breast or lymph nodes? Please submit chart notes.
If patient is ER and/or PR positive and HER2- negative, does patient have residual invasive breast cancer in the resected lymph node(s)? Please submit chart notes.
Has patient had at least 6 cycles containing anthracyclines, taxanes or both? ☐ Yes ☐ No Please submit chart notes
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?
Please note: Not all drugs/diagnosis 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
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the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical
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
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:

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

