Rubraca (Rucaparib)
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:	

Continued on next page.

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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:**
□ Deleterious BRCA1 or BRCA2 gene mutated advanced ovarian cancer □ Deleterious BRCA1 or BRCA2 gene mutated fallopian tube cancer □ Deleterious BRCA1 or BRCA2 gene mutated primary peritoneal cancer □ Other diagnosis: _____ICD-10_____ *Lab documentation of BRCA mutation must be submitted.	

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

Clinical Information:

Does the patient have a history of failure, contraindication, or intolerance to two or more prior lines of chemotherapy AND has at least one therapy been platinum-based?* □ Yes □ No
Chart documentation must be submitted along with dates of trials.

For <u>recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in complete or partial response to platinum-based chemotherapy</u>

Does the patient have a high grade (grade 2 or 3) serous or endometrioid epithelial ovarian, fallopian tube, or primary peritoneal cancer? □ Yes □ No

How many platinum-based regimens has the patient received? _____

Was the most recent platinum-based regimen a chemotherapy doublet? □ Yes □ No

How many cycles of platinum chemotherapy has the patient received? _____
Please provide the date of the last dose: _____

Is the patient currently in a complete <u>OR</u> partial response to platinum-based chemotherapy as defined by RECIST criteria? □ Yes □ No

Have any other anticancer MAINTENANCE treatments been adminestered in the interval perdio between completion of the most recent platinum-based therapy and initiation of Rubraca? □ Yes □ No

If the patient is a <u>PARTIAL RESPONSDER</u> to platinum therapy, what is their CA-125 level?

Has the patient received prior treatment with any PARP inhibitors (ie olaparib/Lynparza, niraparib/Zejula, rucaparib/Rubraca) to date? □ Yes □ No

Has the patient required drainage of ascites during the final TWO cycles of the lsat platinum-based reigmen? □ Yes □ No

Does the patient have sympotamic and/or untreated CNS metastases? □ Yes □ No

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 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; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909