PARAMOUNT
Affiliate of ProMedica

Criteria: STD
Approved: 9/2018
Verified: 12/2019
Reviewed:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Tagrisso

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025**. You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Tagrisso.

Drug Name (select from list of drugs shown)

Other, Please specify Tagrisso (osimertinib)

Quantity _____ **Frequency** _____ **Strength** _____

Route of Administration _____ **Expected Length of Therapy** _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of metastatic non-small cell lung cancer? Y N
   [If no, no further questions.]
2. Does the patient have epidermal growth factor receptor (EGFR) T790M mutation positive NSCLC as detected by an FDA approved test? Y N
   [If no, skip to question 4.]
3. Has the disease progressed on or after EGFR TKI therapy? Y N
   [No further questions.]
4. Does the patient have EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test? Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date