UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Trodelvy (sacituzumab govitecan-hziy)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: *(all of the following criteria must be met)*

❑ Diagnosis of one of the following: *(select applicable)*

❑ Unresectable locally advanced or metastatic triple-negative breast cancer (mTNBC) who have received two or more prior systemic therapies, at least one of them for metastatic disease.

- Previous therapy:_____Chart Note Page #: _____
- Previous therapy:_____Chart Note Page #: _____

❑ Locally advanced or metastatic urothelial cancer OR metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative (IHC 0, IHC 1+ or IHC 2+/ISH–) breast cancer who have received endocrine-based therapy and at least two additional systemic therapies in the metastatic setting. .

- Previous therapy:_____Chart Note Page #: _____
- Previous therapy:_____Chart Note Page #: _____

❑ Locally advanced or metastatic urothelial cancer (mUC) who have previously received a platinum-containing chemotherapy and either programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor.

- Previous therapy:_____Chart Note Page #: _____
- Previous therapy:_____Chart Note Page #: _____

- ❑ Trodelvy will not be used with other drugs containing irinotecan or its active metabolite SN-38.

Re-authorization Criteria:
Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

Note:

- Severe or life threatening neutropenia may occur. The provider should withhold Trodelvy for absolute neutrophil count below 1500/mm3 or neutropenic fever and monitor blood cell counts periodically during treatment.
- Severe diarrhea may occur. The provider should monitor patients with diarrhea and give fluid and electrolytes as needed.

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date