EXPRESS SCRIPTS®

Clear Print

Prior Authorization Request

LYNPARZA (olaparib)

Instructions

Please complete Part A and have your physician complete Part B. Completion and submission is not a guarantee of approval. Any fees related to the completion of this form are the responsibility of the plan member. Drugs in the Prior Authorization Program may be eligible for reimbursement if the patient does not qualify for coverage under a primary plan or a government program. Drugs used for indications not approved by Health Canada may be denied. For Quebec plan members, RAMQ exception drug criteria may apply. The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based clinical protocols. The plan member will be notified whether their request has been approved or denied. Please note that you have the right to appeal the decision made by Express Scripts Canada.

Part A – Patient

Patient information

First Name:	Last Name:	
Insurance Carrier Name/Number:		
Group Number:	Client ID:	
Date of Birth (YYYY/MM/DD):	Relationship: ☐ Employee ☐ Spouse ☐ Dependent	
Language: ☐ English ☐ French	Gender: ☐ Male ☐ Female	
Address:		
City:	Province:	Postal Code:
Email address:		
Telephone (home):	Telephone (cell):	Telephone (work):

Coordination of benefits

Patient Assistance Program	Is the patient enrolled in any patient assistance program? ☐ Yes ☐ No Contact Name: _____ Fax: _____
Provincial Coverage	Has the patient applied for reimbursement under a provincial plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****
Primary Coverage	Has the patient applied for reimbursement under a primary plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****

Authorization

On behalf of myself and my eligible dependents, I authorize my group benefit provider, and its agents, to exchange the personal information contained on this form. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as my dependents and I are covered by, or are claiming benefits under the present group contract, or any modification, renewal, or reinstatement thereof.

_____ _____

Plan Member Signature Date

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Part B – Prescriber

Please see instructions on page 1 and complete all sections below. Incomplete forms may result in automatic denial. Please do **not** provide genetic test information or results.

SECTION 1 – DRUG REQUESTED

LYNPARZA (olaparib)		☐ New request	☐ Renewal request*
Dose	Administration (ex: oral, IV, etc)	Frequency	Duration

Site of drug administration:

☐ Home ☐ Physician's office/Infusion clinic ☐ Hospital (outpatient) ☐ Hospital (inpatient)

* Please submit proof of prior coverage if available

SECTION 2 – ELIGIBILITY CRITERIA

1. **Please indicate if the patient satisfies the below criteria:**

Breast Cancer – Adjuvant

- ☐ For the adjuvant treatment of deleterious or suspected deleterious germline BRCA-mutated (BRCAm), human epidermal growth factor receptor 2 (HER2)-negative high-risk early breast cancer in an adult, AND
- ☐ The patient has been treated with neoadjuvant or adjuvant chemotherapy *(Please list prior therapies in the chart below)*

Breast Cancer – Metastatic

- ☐ For the treatment of human epidermal growth factor receptor 2 (HER2)-negative metastatic breast cancer in an adult, AND
- ☐ The patient has been previously treated with chemotherapy *(Please list prior therapies in the chart below)*, AND
- ☐ The patient is hormone receptor (HR)-positive and has progressed on or is considered to be inappropriate for endocrine therapy, OR
- ☐ The patient is HR-negative, AND
- ☐ LYNPARZA will be used as monotherapy

Epithelial Ovarian, Fallopian Tube or Primary Peritoneal Cancer – Advanced

- ☐ For the maintenance treatment of advanced high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer in an adult, AND
- ☐ The patient has completed between 6 and 9 cycles of first-line platinum-based chemotherapy, AND
- ☐ The patient has had a complete or partial response to platinum-based chemotherapy *(Please list prior therapies in the chart below)*, AND
- ☐ LYNPARZA will be used as monotherapy

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Epithelial Ovarian, Fallopian Tube or Primary Peritoneal Cancer – Recurrent

- ☐ For the maintenance treatment of platinum-sensitive relapsed (PSR) high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer in an adult, AND
- ☐ The patient has had a complete or partial response to 2 lines of platinum-based chemotherapy *(Please list prior therapies in the chart below)*, AND
- ☐ The patient has had a complete or partial response to the most recent platinum-based chemotherapy, AND
- ☐ LYNPARZA will be used as monotherapy

Pancreatic Adenocarcinoma

- ☐ For the maintenance treatment of pancreatic adenocarcinoma in an adult, AND
- ☐ The patient's disease has not progressed on at least 16 weeks of platinum-based chemotherapy, AND
- ☐ The patient has had a complete or partial response to platinum-based chemotherapy *(Please list prior therapies in the chart below)*, AND
- ☐ LYNPARZA will be used as monotherapy

Prostate Cancer

- ☐ For the treatment of metastatic castration-resistant prostate cancer (mCRPC) in an adult, AND
- ☐ The patient's disease has progressed following prior treatment with a hormonal agent *(Please list prior therapies in the chart below)*, AND
- ☐ LYNPARZA will be used as monotherapy

Prostate Cancer – BRCA Mutated

- ☐ For the treatment of deleterious or suspected deleterious BRCA mutated metastatic castration-resistant prostate cancer (mCRPC) in an adult whom chemotherapy is not clinically indicated, AND
- ☐ The patient has not received prior systemic therapy in the mCRPC setting, AND
- ☐ The patient has experienced disease progression despite bilateral orchiectomy, OR
- ☐ LYNPARZA will be used in combination with a gonadotropin-releasing hormone (GnRH) analog *(Please list prior therapies in the chart below)*, AND
- ☐ LYNPARZA will be used in combination with abiraterone, AND
- ☐ LYNPARZA will be used in combination with prednisone or prednisolone

OR

- ☐ None of the above criteria applies.

Relevant additional information:

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2. Please list previously tried therapies

Drug	Dosage and administration	Duration of therapy		Reason for cessation	
		From	To	Inadequate response	Allergy/ Intolerance
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

SECTION 3 – PRESCRIBER INFORMATION

Physician's Name:	
Address:	
Tel:	Fax:
License No.:	Specialty:
Physician Signature:	Date:

Please fax or mail the completed form to Express Scripts Canada®

Fax: Express Scripts Canada Clinical Services
1 (855) 712-6329

Mail: Express Scripts Canada Clinical Services
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5