Arzerra

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)* ❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)* ❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

Strength/Measure _____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____ *Route of administration* _____
Dosing frequency _____

What is the ICD-10 code? _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org

Criteria Questions:

1. What is the patient's diagnosis?

❒ Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL), *Continue to 2*

❒ Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma (WM/LPL), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Is this a request for continuation of therapy with the requested drug?

❒ Yes, *Continue to 3*

❒ No, *Continue to 4*

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

4. What is the patient's diagnosis?

❒ Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL), *No further questions*

❒ Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma (WM/LPL), *Continue to 5*

5. What is the clinical setting in which the requested medication will be used?

❒ Relapsed disease, *Continue to 6*

❒ Refractory disease, *Continue to 6*

❒ Progressive disease, *Continue to 6*

❒ Other, please specify. _____, *Continue to 6*

6. Is the patient intolerant to rituximab?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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