Gazyva

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? _____

Criteria Questions:

1. Is this a request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 2*
❒ No, *Continue to 5*

2. Is there evidence of disease progression or unacceptable toxicity while on the current regimen?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

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3. What is the patient's diagnosis?

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

❒ Follicular lymphoma (FL), *Continue to 4*

❒ Extranodal marginal zone lymphoma (gastric MALT lymphoma), *No further questions*

❒ Extranodal marginal zone lymphoma (non-gastric MALT lymphoma), *No further questions*

❒ Nodal marginal zone lymphoma, *No further questions*

❒ Splenic marginal zone lymphoma, *No further questions*

❒ Hairy cell leukemia, *No further questions*

❒ Diffuse Large B-Cell Lymphoma when used as pre- treatment with glofitamab (Columvi), *Continue to 22*

❒ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, *No further questions*

❒ Mantle cell lymphoma (MCL), *No further questions*

❒ Diffuse large B-cell lymphoma, *No further questions*

❒ High-grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified), *No further questions*

❒ Burkitt lymphoma, *No further questions*

❒ HIV-related B-cell lymphoma, *No further questions*

❒ Post-transplant lymphoproliferative disorder, *No further questions*

❒ Castleman's Disease, *No further questions*

❒ Other, please specify. _____, *No further questions*

4. How many months of therapy with the requested medication has the patient received in their current course of therapy?

_____months, *No further questions*

5. What is the patient's diagnosis?

❒ Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL), *Continue to 18*

❒ Follicular lymphoma (FL), *Continue to 6*

❒ Extranodal marginal zone lymphoma (gastric MALT lymphoma), *Continue to 13*

❒ Extranodal marginal zone lymphoma (non-gastric MALT lymphoma), *Continue to 13*

❒ Nodal marginal zone lymphoma, *Continue to 14*

❒ Splenic marginal zone lymphoma, *Continue to 13*

❒ Hairy Cell Leukemia, *Continue to 19*

❒ Diffuse Large B-Cell Lymphoma when used as pre- treatment with glofitamab (Columvi), *Continue to 22*

❒ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, *Continue to 16*

❒ Mantle cell lymphoma (MCL), *Continue to 16*

❒ Diffuse large B-cell lymphoma, *Continue to 16*

❒ High-grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified), *Continue to 16*

❒ Burkitt lymphoma, *Continue to 16*

❒ HIV-related B-cell lymphoma, *Continue to 16*

❒ Post-transplant lymphoproliferative disorder, *Continue to 16*

❒ Castleman's Disease, *Continue to 16*

❒ Other, please specify. _____, *No further questions*

6. How will the requested medication be used?

❒ The requested medication will be used as first line therapy, *Continue to 8*

❒ The requested medication will be used as subsequent therapy, *Continue to 9*

❒ The requested medication will be used as maintenance therapy, *Continue to 10*

❒ The requested medication will be used as a substitute for rituximab, *Continue to 7*

❒ Other, please specify. _____, *No further questions*

7. Has the patient experienced intolerance or rare complications from rituximab such as mucocutaneous reactions including paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis? Note: Re-challenge with the same anti-CD20 monoclonal antibody is not recommended and it is unclear if the use of an alternative anti-CD20 monoclonal antibody poses the same risk of recurrence.

❒ Yes, *Continue to 12*

❒ No, *Continue to 12*

8. Will the requested drug be used in combination with any of the following?

❒ CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone), *Continue to 12*

❒ CVP (cyclophosphamide, vincristine and prednisone), *Continue to 12*

❒ Bendamustine, *Continue to 12*

❒ Other, please specify. _____, *Continue to 12*

9. In which of the following regimens will the requested drug be used?

❒ In combination with CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone), *Continue to 12*

❒ In combination with CVP (cyclophosphamide, vincristine and prednisone), *Continue to 12*

❒ In combination with bendamustine, *Continue to 12*

❒ In combination with lenalidomide, *Continue to 12*

❒ As a single agent, *Continue to 12*

❒ In combination with zanubrutinib, *Continue to 11*

❒ Other, please specify. _____, *No further questions*

10. Will the requested drug be used as a single agent?

❒ Yes, *Continue to 12*

❒ No, *Continue to 12*

11. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment, *Continue to 12*

❒ Second-line treatment, *Continue to 12*

❒ Third-line and subsequent therapy, *Continue to 12*

12. How many months of therapy with the requested medication has the patient received in their current course of therapy?

_____months, *No further questions*

13. How will the requested medication be used?
❒ The requested medication will be used as subsequent therapy in combination with bendamustine, *No further questions*
❒ The requested medication will be used as subsequent therapy in combination with lenalidomide, *No further questions*
❒ The requested medication will be used as maintenance therapy in a patient who has been treated with the requested medication and bendamustine, *No further questions*

❒ The requested medication will be used as a substitute for rituximab, *Continue to 17*

❒ Other, please specify. _____, *Continue to 17*

14. How will the requested medication be used?

❒ The requested medication will be used as first-line therapy, *Continue to 15*
❒ The requested medication will be used as subsequent therapy in combination with bendamustine, *No further questions*
❒ The requested medication will be used as subsequent therapy in combination with lenalidomide, *No further questions*
❒ The requested medication will be used as maintenance therapy in a patient who has been treated with the requested medication and bendamustine, *No further questions*

❒ The requested medication will be used as a substitute for rituximab, *Continue to 17*
❒ Other, please specify. _____, *No further questions*

15. Will the requested drug be used in combination with any of the following?

❒ CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) regimen, *No further questions*

❒ CVP (cyclophosphamide, vincristine and prednisone) regimen, *No further questions*

❒ Bendamustine, *No further questions*

❒ Other, please specify. _____, *No further questions*

16. Will the requested medication be used as a substitute for rituximab?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Has the patient experienced intolerance or rare complications from rituximab such as mucocutaneous reactions including paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis? Note: Re-challenge with the same anti-CD20 monoclonal antibody is not recommended and it is unclear if the use of an alternative anti-CD20 monoclonal antibody poses the same risk of recurrence.

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

18. How will the requested medication be used?

❒ The requested medication will be used as a single agent, *No further questions*

❒ The requested medication will be used in combination with acalabrutinib, *No further questions*

❒ The requested medication will be used in combination with venetoclax, *No further questions*

❒ The requested medication will be used in combination with bendamustine, *No further questions*

❒ The requested medication will be used in combination with chlorambucil, *No further questions*

❒ Other, please specify. _____, *No further questions*

19. Will the requested drug be used in combination with any of the following?

❒ The requested medication will be used in combination with vemurafenib, *Continue to 20*

❒ Other, please specify. _____, *Continue to 20*

20. What is the place in therapy in which the requested medication will be used?

❒ Initial therapy, *Continue to 21*

❒ Other, please specify. _____, *Continue to 21*

21. Is the patient able to tolerate purine analogs?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

22. Will the patient receive the requested medication as pre-treatment for up to 1 dose in cycle 1 of glofitamab (Columvi) therapy?
❒ 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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