



# Lumoxiti

## 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 along with supporting clinical documentation 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  Home  Off Campus Outpatient Hospital
- On Campus Outpatient Hospital  Office

### Drug Information:

Strength/Measure \_\_\_\_\_ Units  ml  Gm  mg  ea  Un  
Directions(sig) \_\_\_\_\_ Route of administration \_\_\_\_\_  
Dosing frequency \_\_\_\_\_

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Lumoxiti SGM 2739-A – 01/2023.

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

**Criteria Questions:**

1. What is the diagnosis?  
 Relapsed or refractory hairy cell leukemia  
 Other, please specify \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?  
 Yes  No *If No, skip to #7*
4. How many systemic therapies has the patient received previously? \_\_\_\_\_
5. Has the patient previously received treatment with a purine nucleoside analog?  Yes  No
6. Is the requested medication being used as a single agent?  Yes  No
7. How many cycles of treatment with the requested drug has the patient already received? \_\_\_\_\_

*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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