

Pharmacy PRIOR AUTHORIZATION FORM

Last Reviewed: December 2011

2012 Priority Medicare Formulary

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Arzerra[®] (ofatumumab)

URGENT (life threatening)

Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

PROVIDER NAME:

Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature

Date

PRODUCT INFORMATION

Arzerra[®] 100mg/5ml

Dose: _____

Start date: _____

Coverage Duration: When authorized, coverage is given for 24 weeks.

BILLING INFORMATION

Place of administration:

- Provider's Office
 Outpatient Infusion Center
Center Name: _____
 Home Infusion
Agency Name: _____

Billing Options:

- Physician buy and bill
 Preferred Specialty Vendor
 Other: _____

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for Arzerra[®] (ofatumumab) requires the following information to certify:

Patient must have met the following requirements:

- Diagnosis of Chronic lymphocytic leukemia (CLL) refractory to fludarabine and alemtuzumab.
- Trial and failure with, or inability to take, chlorambucil

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for Arzerra® (ofatumumab) requires the following information to certify:

A. Patient has a diagnosis of chronic lymphocytic leukemia (CLL) refractory to fludarabine (Fludara®) and alemtuzumab (Campath®):

Yes

No – Rationale for use: _____

B. Has the patient had a trial and failure with, or inability to take, chlorambucil?

Yes

No – Rationale for use: _____

PRIORITY MEDICARE PLANS

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

FOR MEDICARE ONLY

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2. The number of doses available under a dose restriction for the prescription drug:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
 - c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.

4. None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

***** All fields must be complete and legible for Prior Authorization Review*****

Please fax this request to: (877)974-4411 toll free or (616)942-8206

YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX