

Pharmacy Prior Authorization Form

Last reviewed: Nov 11

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 (part B)

Oforta[®] (fludarabine)

Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Oforta tablets 10 mg

Dose: _____ Cycle Frequency: _____ Start date: _____ Expected Duration: _____

Priority Health precertification requirement:

Authorization of Oforta requires:

- Documented diagnosis of B-Cell chronic lymphocytic leukemia
- Documented failure of or intolerance to an appropriate trial of at least one standard alkylating-agent containing chemotherapy regimen
- Monitoring for CNS toxicity, hemolytic anemia, and pulmonary toxicity while on therapy.
- Contraindicated with Nipent (pentostatin)
- Off-label Use Coverage for Other Cancer Diagnoses:

Coverage for other cancer diagnoses may be authorized provided effective treatment with such drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature. Priority Health may authorize coverage for use for other cancer diagnoses provided effective treatment with such drug is recognized as a "Medically Accepted Indication" according to the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium as indicated by a Category 1 or 2A for quality of evidence and level of consensus.

Please Complete the Following Information:

Diagnosis:

- Chronic lymphocytic leukemia
- Failure of or intolerance to an appropriate trial of at least one standard alkylating-agent containing chemotherapy regimen.
- Other: _____ Please provide rationale for use (see off-label use above):

Duration of Approval:

If these criteria are met, a 6-month authorization will be granted. The authorization may be extended based on patient response.

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX