PriorityHealth

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**

Zevalin® (Ibritumomab tiuxetan)

☐ 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:

- ☐ Zevalin Injection 3.2 mg vial

Dose: ______________________________ Start date: ____________________

Place of administration:

- ☐ Self-administered
- ☐ Provider's Office
- ☐ Outpatient Infusion Center Name of center: ______________________________
- ☐ Home Infusion Name of agency: ______________________________

Billing options:

- ☐ Physician buy and bill (A9522 or A9523)
- ☐ Preferred Specialty Vendor
- ☐ Other: ____

Priority Health Precertification Requirements:

Authorization of Zevalin requires:

- Diagnosis of relapsed or refractory B-cell, non-Hodgkin's lymphoma or Rituximab refractory B-cell, non-Hogdkin's lymphoma
- Platelet count greater than 100,000/mm^3
- Less than 25% bone marrow involvement
- Neutrophil count greater than 1500/mm^3
- Must not have prior myeloablative therapies with autologous bone marrow transplantation or peripheral blood stem cell collection
- Must not have history of failed stem cell collection

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Please Complete the following Information:

Diagnosis:

- ☐ Relapsed or refractory low grade, follicular, or transformed B-cell non-Hodgkin's lymphoma–
  ICD code: ______________________________
- ☐ Rituximab refractory follicular B-cell non-Hodgkin's lymphoma, exhibited by a less than adequate response and/or a response of less than six months-ICD code: ______________________________
- ☐ Other: __________________ ICD code: _________________ Please provide rationale for use:
  ____

Prescriber is an oncologist:

- ☐ Yes
- ☐ No

Patient's platelet count is greater than 100,000/mm^3:

- ☐ Yes
- ☐ No – Rationale for use: ____

Bone marrow involvement is less than 25%:

- ☐ Yes
- ☐ No – Rationale for use: ____

Patient's neutrophil count is greater than 1500/ mm^3:

- ☐ Yes
- ☐ No – Rationale for use: ____

Exclusion Criteria: (Any one of the following will exclude patient from treatment); **(Check those that apply)**
Patient has at least one of the following exclusions:

- ☐ Yes – Rationale for use: ____
  - ☐ Prior myeloablative therapies with autologous bone marrow transplantation or peripheral blood stem cell collection
  - ☐ History of failed stem cell collection
  - ☐ History of external radiation to greater than or equal to 25% of active marrow
- ☐ No

Note: Priority Health Medicare applies CMS local coverage determination criteria when available for Part B drugs. If no 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.

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX