

**Medical prior authorization form**

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to:  **Commercial (Traditional)**     **Commercial (Individual/Optimized)**

**Medicaid**

This request is:  **Urgent** (life threatening)     **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

**Arzerra<sup>®</sup>** (ofatumumab)

**Member**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

ID #: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Requesting Physician: \_\_\_\_\_ Prov. Phone: \_\_\_\_\_ Prov. Fax: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician NPI: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Product and Billing Information**

New request     Continuation request

Drug product:     Arzerra 100 mg/5 mL vial

**Start date** (or date of next dose): \_\_\_\_\_

**Date of last dose** (if applicable): \_\_\_\_\_

**Date of next dose** (if applicable): \_\_\_\_\_

**Dose:** \_\_\_\_\_ **Dose Frequency:** \_\_\_\_\_

Place of administration:  Physician's office  
 Outpatient infusion

Facility: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

Home infusion

Facility: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

Billing:  Physician to buy and bill  
 Facility to buy and bill  
 Specialty Pharmacy

Pharmacy: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

ICD-10 Diagnosis code(s): \_\_\_\_\_

**Precertification Requirements**

**Before this drug is covered, documentation of the following must be provided:**

1. Diagnosis of Chronic Lymphoid Leukemia (CLL)
  - With complete or partial response after 2 lines of therapy for recurrent or progressive disease, as extended treatment
  - Previously untreated, in combination with chlorambucil, when fludarabine-based therapy is considered inappropriate
  - Refractory to fludarabine and alemtuzumab
  - Relapsed, in combination with fludarabine and cyclophosphamide

**Note:** Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

**New request**  
**Priority Health Precertification Documentation**

**A. What condition is this drug being requested for?**

- Previously untreated Chronic Lymphoid Leukemia (CLL)
  - 1) Will Arzerra be used in combination with chlorambucil?
    - Yes
    - No. *Rationale or use:* \_\_\_\_\_
  - 2) Is fludarabine-based therapy considered inappropriate?
    - Yes. *For what reason:* \_\_\_\_\_
    - No. *Rationale or use:* \_\_\_\_\_
- CLL refractory to fludarabine and alemtuzumab
- CLL with complete or partial response after trial of 2 lines of therapy for recurrent or progressive disease
- Relapsed CLL in combination with fludarabine and cyclophosphamide
- Other: \_\_\_\_\_

**B. Please specify previous drug trials below:**

Drug	Dose	Dates of Use	Therapy Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____