Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☐ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Arzerra™ (ofatumumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Drug 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): _____

Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically-accepted indication*

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System. For chemotherapy, other reference books may apply)

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 01/2018
Last reviewed 11/2018

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Chronic Lymphoid Leukemia (CLL)
- ☐ *Other – the patient's condition is:* _____

B. Is the patient using Arzerra in combination with chlorambucil?

- ☐ Yes
- ☐ No. *Rationale for use:* _____

C. Has the patient used fludarabine and alemtuzumab?

- ☐ Yes
- ☐ No. *Rationale for use:* _____

D. Is this being used as extended treatment for a patient in complete or partial response after at least 2 lines of therapy for recurrent or progressive disease?

- ☐ Yes
- ☐ No. *Rationale for use:* _____

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Arzerra likely be the most effective option for this patient?

- ☐ No
- ☐ Yes, because: _____

If the patient is currently using Arzerra, would changing the patient's current regimen likely result in adverse effects for the patient?

- ☐ No
- ☐ Yes, because: _____

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Last reviewed 11/2018