PriorityHealth

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.

Gazyva® (obinutuzumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Gazyva 1,000 mg/40 mL vial

Dose: _____ **Dose Frequency**: _____

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose: _____

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): _____

Drug cost information

The wholesale acquisition cost for a 24-week treatment with this drug is $42,415.20.

Precertification Requirements

Before this drug is covered, the patient must meet one of the following requirements:

1. Must have chronic lymphocytic leukemia, and:
   a. Must be treatment naïve, and
   b. Must be used in combination with Leukeran.

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

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Last reviewed 11/2018

2. Must have follicular lymphoma, and:
    a. Have relapsed after, or are refractory to, a rituximab-containing regimen
    b. Must be used in combination with bendamustine (e.g., Bendeka, Treanda)
3. Must have follicular lymphoma, and:
    a. Have previously untreated bulky stage II, III, or IV disease in those with at least a partial response to combination therapy
    b. Must be used in combination with chemotherapy followed by obinutuzumab monotherapy

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.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Chronic lymphocytic leukemia (CML)
- ☐ Follicular lymphoma
- ☐ Other – rationale for use: _____

B. Answer the applicable questions below.

chronic lymphocytic leukemia	**Was the patient's condition previously treated with an anti-cancer drug treatment?** ☐ Yes ☐ No **Will Gazyva be given in combination with Leukeran?** ☐ Yes ☐ No
follicular lymphoma	**Has the patient previously been treated with Rituxan?** ☐ Yes ☐ No **Will Gazyva be given in combination with Bendeka or Treanda?** ☐ Yes ☐ No

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