PriorityHealth

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.

Gazyva® (obinutuzumab)

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: _____

Product and Billing Information

☐ New request ☐ Continuation request

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

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

ICD-10 Diagnosis code(s): _____

Place of administration:

☐ Physician's office

☐ Outpatient infusion

Facility: _____ NPI: _____ Fax: _____

☐ Home infusion

Facility: _____ NPI: _____ Fax: _____

Billing:

☐ Patient will fill at pharmacy under their Part D benefit

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy: _____ NPI: _____ Fax: _____

Precertification Requirements

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

1. Must be used to treat chronic lymphocytic leukemia in combination with Leukeran for treatment naïve patients; or
2. Must be used to treat follicular lymphoma after prior treatment with Rituxan.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 05/2016

Last reviewed 11/2019

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, the DRUGDEX Information System, and the USPDI or its successor.)

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

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

B. Answer the applicable questions below.

chronic lymphocytic leukemia	follicular lymphoma
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	**Has the patient previously been treated with Rituxan?** ☐ Yes ☐ No

Priority Health Medicare plans

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

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 Gazyva likely be the most effective option for this patient?

- ☐ No
- ☐ Yes, because: _____

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

- ☐ No
- ☐ Yes, because: _____

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