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.

Zevalin® (ibritumomab tiuxetan)

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: _____ ☐ Oncologist

Product and Billing Information

Drug product: ☐ Zevalin 3.2 mg/2 mL kit (Y-90)

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 code(s): _____

Precertification Requirements

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

1. Relapsed or refractory, low-grade or follicular B-cell non-Hodgkin's lymphoma (NHL) or rituximab refractory B-cell NHL
   a. Platelet count $\geq$ 100,000/mm^3
2. Previously untreated follicular NHL in a patient who achieved a partial or complete response to first-line chemotherapy
   a. Must be administered at least 6 weeks but no more than 12 weeks following the last dose of chemotherapy
   b. Platelet count $\geq$150,000/mm^3
3. Less than 25% bone marrow involvement
4. Neutrophil count greater than 1,500/mm^3
5. Must not have prior myeloablative therapies with autologous bone marrow transplantation or peripheral blood stem cell collection
6. Must not have history of failed stem cell collection

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 11/2017

Last reviewed 11/2018

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 is the patient's diagnosis?

- ☐ Relapsed or refractory, low-grade or follicular B-cell non-Hodgkin's lymphoma (NHL)
- ☐ Rituximab-refractory B-cell NHL, exhibited by less than adequate response and/or a response less than six months
- ☐ Previously untreated follicular NHL with a partial or complete response upon completion of first-line chemotherapy
- ☐ Other – rationale for use: _____

B. Is the patient's platelet count greater than or equal to 100,000/mm^3?

☐ Yes ☐ No, rationale for use: _____

C. Is the patient's platelet count greater than or equal to 150,000/mm^3?

☐ Yes ☐ No, rationale for use: _____

D. Is there less than 25% bone marrow involvement?

☐ Yes ☐ No, rationale for use: _____

E. Is the patient's neutrophil count greater than 1,500/mm^3?

☐ Yes ☐ No, rationale for use: _____

F. Which of the following apply to the patient?

(any of the following will exclude patient from authorization)

- ☐ 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

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Last reviewed 11/2018