PriorityHealth

Pharmacy 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.

Zydelig® (idelalisib)

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 Information

☐ New request ☐ Continuation request

Drug product:

☐ Zydeliq 100mg tablet

☐ Zydeliq 150mg tablet

Start date (or date of next dose): ____________

Date of last dose (if applicable): ____________

Dosing frequency: ____________

Drug cost information

The wholesale acquisition cost for one tablet is $131.88. The annual cost of treatment with this drug is more than $96,000.

Precertification Requirements

Patient must meet the following criteria:

1. Relpased chronic lymphocytic leukemia (CLL), in combination with rituximab
2. Relapsed follicular lymphoma (FL), after 2 previous treatments
3. Relapsed small lymphocytic lymphoma (SLL), after 2 previous treatments

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.

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

No changes made since 09/2018
Last reviewed 09/2018

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Priority Health Precertification Documentation

1. **What condition is this drug being requested for?**
   - ☐ Relapsed chronic lymphocytic leukemia (given in combination with rituximab)
   - ☐ Relapsed follicular lymphoma (requires 2 previous treatments)
   - ☐ Relapsed small lymphocytic lymphoma (requires 2 previous treatments)
   - ☐ Other – the patient's condition is: ______________________________

2. **What previous treatment(s) has/have the patient used?** (e.g. Rituxan, bendamustine, chlorambucil, fludarabine, cyclophosphamide)

   Previous therapy: ______________________________ Date: ____________________
   Previous therapy: ______________________________ Date: ____________________
   Previous therapy: ______________________________ Date: ____________________

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