OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Zynlonta® (Loncastuximab Tesirine-lpyl)
Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

❑Physician billing (HCPCS code:_____) ❑Pharmacy billing (NDC:_____)

Start Date (or date of next dose):_____ Dose:_____

Dosing Regimen: Cycles 1 & 2_____ Subsequent Cycles:_____

Billing Provider Information

Provider NPI:_____ Provider Name:_____

Provider Phone:_____ Provider Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

For Initial Authorization

1. Please indicate the diagnosis and information:

❑ Diffuse Large B-cell Lymphoma (DLBCL)

A. Please select 1 of the following:
   - ____ DLBCL not otherwise specified
   - ____ DLBCL arising from low grade lymphoma
   - ____ High-grade B-cell lymphoma
   - ____ Other, please specify: _____

B. Is disease relapsed or refractory after 2 or more lines of systemic therapy? Yes____ No____

C. Was previous CD19-directed therapy was used? Yes____ No____
   i. If yes, does the member have a biopsy that shows CD19 protein expression after completion of the CD19-directed therapy? Yes___ No____
      1. If yes, please provide biopsy results.

D. Please provide a patient-specific, clinically significant reason why tafasitamab in combination with lenalidomide is not appropriate for the member:

_____

❑ If diagnosis is not listed of the above, please indicate diagnosis:_____

Additional Information:_____

For Continued Authorization:

1. Date of last dose:_____
2. Does the member have any evidence of progressive disease while on Zynlonta®? Yes____ No____
3. Has the member experienced adverse drug reactions related to Zynlonta® therapy? Yes____ No____

*If yes, please specify adverse reactions:*_____

Prescriber Signature:_____ Date:_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Failure to complete this form in full will result in processing delays.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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