

Gazyva® (Obinutuzumab) Prior Authorization Form

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

Drug Information

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

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

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. Will obinutuzumab be used as a single-agent? Yes ___ No ___
2. Will obinutuzumab be used as first-line therapy? Yes ___ No ___
3. Will obinutuzumab be used as second-line or subsequent therapy? Yes ___ No ___
4. Will obinutuzumab be used in combination with bendamustine? Yes ___ No ___
5. Please indicate the diagnosis and information:
 - Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)**
 - A. Will obinutuzumab be used in combination with one of the following? Yes ___ No ___
 chlorambucil ___ ibrutinib ___ venetoclax ___ (please select one, if applicable)
 - i. If applicable, please completely fill out and submit the Imbruvica® (ibrutinib) Prior Authorization Form (Pharm-101) or the Venclexta® (venetoclax) Prior Authorization Form (Pharm-102) that is available on the OHCA website: www.okhca.org.
 - B. Will obinutuzumab be used in relapsed or refractory disease? Yes ___ No ___
 - Follicular Lymphoma (FL)**
 - A. Will obinutuzumab be used for any of the following for members with Grade 1 or 2 disease:
 - i. Stage I (≥7cm)? Yes ___ No ___
 - ii. Contiguous Stage II (≥7cm)? Yes ___ No ___
 - iii. Noncontiguous Stage II, Stage III, or Stage IV? Yes ___ No ___
 - B. Will obinutuzumab be used in combination with any of the following:
 - i. CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone)? Yes ___ No ___
 - ii. CVP (cyclophosphamide, vincristine, and prednisone)? Yes ___ No ___
 - C. Will obinutuzumab be used as maintenance therapy? Yes ___ No ___
 - Gastric or Nongastric Mucosa-Associated Lymphoid Tissue (MALT) Lymphoma, Nodal or Splenic Marginal Zone Lymphoma (MZL)**
 - A. Is the member refractory to a rituximab regimen? Yes ___ No ___
 - B. Will obinutuzumab be used as maintenance therapy as second-line consolidation or extended dosing? Yes ___ No ___
 - If diagnosis is not listed above, please indicate diagnosis:** _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on obinutuzumab? Yes ___ No ___
3. Has the member experienced any adverse drug reactions related to obinutuzumab 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. Please do not send in chart notes. Specific information will be requested if necessary. 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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