OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Polivy® (Polatuzumab Vedotin-piiq) Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code:_____) Start Date (or date of next dose):_____

Dose:_____ Dosing Regimen:_____

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. Is the diagnosis previously untreated DLBCL not otherwise specified or high-grade B-cell lymphoma? Yes☐ No☐
   i. If yes, does the member have an International Prognostic Index score of ≥2? Yes☐ No☐
   ii. Will polatuzumab vedotin be used in combination with rituximab, cyclophosphamide, doxorubicin, and prednisone (R-CHP)? Yes☐ No☐

B. Is the diagnosis relapsed/refractory DLBCL not otherwise specified or high-grade B-cell lymphoma? Yes☐ No☐
   i. If yes, has the member received at least 2 prior therapies? Yes☐ No☐
   ii. Will polatuzumab vedotin be used in combination with bendamustine and rituximab? Yes☐ No☐
   iii. If using without bendamustine, will member proceed to CAR-T therapy? Yes☐ No☐
   iv. Is member a candidate for transplant, or does member have the intention to proceed to transplant? Yes☐ No☐

☐ If diagnosis is not listed above, please indicate diagnosis:_____

Additional Information: _____

_____

_____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on polatuzumab vedotin?
   Yes☐ No☐
3. Has the member experienced adverse drug reactions related to polatuzumab vedotin 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.*

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