OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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☐
acalabrutinib☐ chlorambucil☐ ibrutinib☐ venetoclax☐ (please select one, if applicable)

i. If applicable, please completely fill out and submit the Calquence® (acalabrutinim) Prior Authorization Form (Pharm-125), 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☐

D. Will obinutuzumab be used as third line or subsequent therapy in members with no response, relapsed, or progressive disease? Yes☐ No☐

E. Will obinutuzumab be used in combination with zanubrutinib? Yes☐ No☐

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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Criteria

5. Please indicate the diagnosis and information: *(continued)*

☐ **Diffuse Large B-Cell Lymphoma (DLBCL)**

A. Is diagnosis relapsed or refractory diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including large B-cell lymphoma (LBCL) arising from follicular lymphoma? Yes☐ No☐

B. Will obinutuzumab be used as lymphoid depletion pretreatment prior to glofitamab? Yes☐ No☐

i. If yes, please completely fill out and submit the Columvi™ (glofitamab-gxbm) Prior Authorization Form (Pharm-250) that is available on the OHCA website: www.okhca.org.

☐ **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:** _____

Additional information: _____

_____

_____

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.

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