SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Adcetris® (Brentuximab Vedotin) Prior Authorization Form

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

Drug Information

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

***Dose:*_____ *Regimen:*_____**

Billing Provider Information

***Provider NPI:*_____ *Provider Name:*_____**

***Provider Phone:*_____ *Provider Fax:*_____**

Prescriber Information

***Prescriber NPI:*_____ *Prescriber Name:*_____**

***Prescriber Phone:*_____ *Prescriber Fax:*_____ *Specialty:*_____**

Criteria

Page 1 of 2—Please complete and return all pages. *Failure to complete all pages will result in processing delays.*

For Initial Authorization:

1. Please indicate the requested information:
   - A. Will brentuximab vedotin be used as a single-agent? Yes ☐ No ☐
   - B. Will brentuximab vedotin be used as a primary treatment? Yes ☐ No ☐
   - C. Will brentuximab vedotin be used in relapsed/refractory disease? Yes ☐ No ☐
   - D. Will brentuximab vedotin be used in combination with cyclophosphamide, doxorubicin, and prednisone (CHP)? Yes ☐ No ☐
2. Please indicate the diagnosis and information:

❑ **Anaplastic Large Cell Lymphoma (ALCL), Primary Cutaneous**
- A. Does member have multifocal lesions or regional nodes? Yes ☐ No ☐

❑ **Anaplastic Large Cell Lymphoma (ALCL), Systemic Diagnosis**
- A. Is the diagnosis previously untreated? Yes ☐ No ☐
- B. Has member received one or more lines of therapy? Yes ☐ No ☐

❑ **Classical Hodgkin Lymphoma**
- A. Is disease previously untreated Stage III or IV? Yes ☐ No ☐
- B. Will brentuximab vedotin be used in combination with doxorubicin, vinblastine, and dacarbazine? Yes ☐ No ☐
- C. Is member a non-autologous stem cell transplant (SCT) candidate with failure of 2 or more multi-agent chemotherapy regimens? Yes ☐ No ☐
- D. Has member failed autologous SCT? Yes ☐ No ☐
- E. Has brentuximab vedotin been previously used in combination with multi-agent chemotherapy? Yes ☐ No ☐
- D. Does member have consolidation after autologous SCT with a high risk of relapse or progression? Yes ☐ No ☐

❑ **Diffuse Large B-Cell Lymphoma (DLBCL) or High Grade Lymphoma**
- A. Is disease CD30+? Yes ☐ No ☐
- B. Is member a non-autologous stem cell transplant (SCT) candidate? Yes ☐ No ☐
- C. Has member transformed to DLBCL from follicular lymphoma or marginal zone lymphoma and received 2 or more lines of therapy for indolent or transformed disease? Yes ☐ No ☐

❑ **Primary Cutaneous Lymphomas – Mycosis Fungoides (MF)/Sézary Syndrome (SS)**

Please complete and return all pages. Failure to complete all pages 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

CONFIDENTIALITY NOTICE

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

Criteria

Page 2 of 2—Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.

2. Please indicate the diagnosis and information, continued:
   - ❑ **Peripheral T-Cell Lymphoma (PTCL)**
     - A. Previously untreated CD30+ disease? Yes ☐ No ☐
     - B. Has member received one or more lines of therapy? Yes ☐ No ☐
   - ❑ **Adult T-Cell Leukemia/Lymphoma**
     - A. Is disease CD30+? Yes ☐ No ☐
     - B. Is member a nonresponder to first-line therapy with chronic/smoldering subtype? Yes ☐ No ☐
     - C. Will brentuximab vedotin be used for first-line therapy for acute or lymphoma subtype? Yes ☐ No ☐
     - D. Will brentuximab vedotin be used for continued treatment in responders to first-line therapy for acute or lymphoma subtype? Yes ☐ No ☐
     - E. Has member received one or more lines of therapy? Yes ☐ No ☐
   - ❑ **T-Cell Lymphoma, Extranodal NK/T-Cell Lymphoma, Nasal Type**
     - A. Is disease CD30+? Yes ☐ No ☐
     - B. Is disease relapsed/refractory following additional therapy with an alternate combination chemotherapy regimen not previously used? Yes ☐ No ☐
   - ❑ **If answer is none of the 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 brentuximab vedotin? Yes ☐ No ☐
3. Has the member experienced any adverse drug reactions related to brentuximab vedotin therapy? Yes ☐ No ☐

   If yes, please specify adverse reactions: _____

Additional Information: _____

_____

Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.
Please do not send in chart notes. Specific information will be requested if necessary

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 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.*