SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Zevalin® (Ibritumomab Tiuxetan) 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

For Initial Authorization:

1. Please indicate the diagnosis and information:

- ❑ **Follicular Lymphoma (FL) (Grade 1-2)**
  - A. Will ibritumomab tiuxetan be used as a single agent? Yes☐ No☐
  - B. Is disease relapsed or refractory? Yes☐ No☐
- ❑ **Follicular Lymphoma (FL) or Marginal Zone Lymphoma (MZL) Transformed to Diffuse Large B-Cell Lymphoma (DLBCL)**
  - A. Will ibritumomab tiuxetan be used as a single agent? Yes☐ No☐
  - B. Did member receive minimal or no chemotherapy prior to histologic transformation to DLBCL? Yes☐ No☐
  - C. Does fluorescence in situ hybridization (FISH) show translocation for any of the following?
    - i. MYC: Yes☐ No☐
    - ii. BCL2: Yes☐ No☐
    - iii. BCL6: Yes☐ No☐
  - D. Please indicate member's response after chemoimmunotherapy:
    ☐ Partial response ☐ Progressive disease ☐ No response
    ☐ Other_____
  - E. For indolent or transformed disease, has member received 2 or more prior therapies of chemoimmunotherapy? Yes☐ No☐
- ❑ **If answer is none of the above, please indicate diagnosis**:_____

For Continued Authorization:

1. Date of last dose:_____
2. Does patient have any evidence of progressive disease while on ibritumomab tiuxetan? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to ibritumomab tiuxetan? 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:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014	*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.*