ATRIO HEALTH PLANS

Chemotherapy: Lymphoid Leukemia Drugs

Arzerra/Kesimpta (ofatumumab) J9302, Bendeka/Treanda (bendamustine HCl) J9034/J9033, Erwinaze (asparaginase erwinia chrysanthemi) J9019, Gazyva (obinutuzumab) J9301, Oncaspar (pegaspargase) J9266, Rylaze (asparaginase) J9021

Prior Authorization Request

Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**NEW START - Start Date:_____**	☐	**Continuation** (within 365 days)**:** Date of last treatment _____
☐	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug ☐ Self-administered	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

For questions or assistance, please contact Customer Service at 1-877-672-8620, daily, 8am – 8pm (PST) (TTY users should call 1-800-735-2900).

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Oncology: NSCLC Meds PA

Drug Name(s):

ARZERRA
BENDEKA
ERWINAZE
GAZYVA
KESIMPTA
ONCASPAR
TREANDA
RYLAZE

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Prescribed by, or in consultation with an oncologist or other cancer specialist related to the diagnosis.
3. Drug is being used appropriately per CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
4. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

Cannot be prescribed for experimental or investigational use.

Prescriber Restrictions:

Oncologist or other cancer specialist

Coverage Duration:

New Start: Approval will be for 6 months
Continuation: Approval will be for 12 months

FDA Indications:

Arzerra, Kesimpta

- Chronic lymphoid leukemia, Extended treatment for patients in complete or partial response after at least 2 lines of therapy for recurrent or progressive disease
- Chronic lymphoid leukemia, Previously untreated, in combination with chlorambucil
- Chronic lymphoid leukemia, Refractory to fludarabine and alemtuzumab
- Chronic lymphoid leukemia, Relapsed, in combination with fludarabine and cyclophosphamide
- Relapsing remitting multiple sclerosis

Bendeka, Treanda

- Chronic lymphoid leukemia
- Non-Hodgkin's lymphoma, Indolent B-cell, refractory to rituximab or rituximab-containing regimens

Gazyva

- Chronic lymphoid leukemia, Previously untreated, in combination with chlorambucil
- Follicular lymphoma, After relapse, or those who are refractory to a rituximab-containing regimen, in combination with bendamustine followed by obinutuzumab monotherapy
- Follicular lymphoma, In combination with chemotherapy followed by obinutuzumab monotherapy, in previously untreated stage II bulky, III, or IV disease in those with at least a partial response to combination therapy

Erwinaze

- Acute lymphoid leukemia, In combination with other chemotherapeutic agents in patients with hypersensitivity to E coli-derived asparaginase

Oncaspar

- Acute lymphoid leukemia, First-line, in combination with other agents
- Acute lymphoid leukemia, In combination with other agents in patients with hypersensitivity to L-asparaginase

Rylaze

- Acute lymphoid leukemia, In combination with other chemotherapy agents; in patients who have developed E. coli-derived asparaginase hypersensitivity
- Lymphoblastic lymphoma, In combination with other chemotherapy agents; in patients who have developed E. coli-derived asparaginase hypersensitivity

Off-Label Uses:

Arzerra, Kesimpta

- Waldenstrom macroglobulinemia

Bendeka, Treanda

- Metastatic breast cancer
- Multiple myeloma
- Non-Hodgkin's lymphoma
- Waldenstrom macroglobulinemia, In combination with rituximab
- Amyloidosis, relapsed or refractory, combination with dexamethasone
- Mantle cell lymphoma, previously untreated, transplant ineligible, in combination with rituximab

Oncaspar

- Acute lymphoid leukemia
- Extranodal NK/T-cell lymphoma, nasal type

Age Restrictions:

Azerra, Bendeka, Gazyva, Kesimpta, Treanda: Safety and effectiveness not established in pediatric patients
Rylaze: 1 month or older

Other Clinical Considerations:

Cancer diagnoses: Criteria as per NCCN or other FDA-approved cancer related guidelines.

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/14AD71/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/659BD9/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=OFATUMUMAB%20&UserSearchTerm=OFATUMUMAB%20&SearchFilter=filterNone&navitem=searchGlobal#

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