OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Columvi™ (glofitamab-gxbm) 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. Will member receive a single dose of obinutuzumab for pre-treatment purposes? Yes☐ No☐
2. Please indicate the diagnosis and information:

☐ **Lymphoma**

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☐
   i. Has the member received 2 or more lines of systemic therapy? Yes☐ No☐

B. Is diagnosis diffuse large B-cell lymphoma (DLBCL)? Yes☐ No☐
   i. Used as second-line and subsequent therapy in combination with GemOx (gemcitabine and oxaliplatin)? Yes☐ No☐
   ii. Is member a candidate for CAR T-cell therapy? Yes☐ No☐
   iii. Does member intend to proceed to transplant? Yes☐ No☐

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

Additional Information: _____

_____

For Continued Authorization:

1. Date of last dose: _____
2. How many cycles of glofitamab-gxbm has the member received? _____
3. Does member have any evidence of progressive disease while on glofitamab-gxbm therapy? Yes☐ No☐
4. Has member experienced any adverse drug reactions related to glofitamab-gxbm 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.*

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *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.*