

## 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. 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  bendamustine  chlorambucil  ibrutinib  venetoclax  (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/rxforms](http://www.okhca.org/rxforms).

B. Will obinutuzumab be used in relapsed or refractory disease? Yes  No

C. Is there a del(17p)/TP53 mutation? Yes  No

**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/rxforms](http://www.okhca.org/rxforms).

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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](http://AetnaBetterHealth.com/Oklahoma).

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**Gazyva® (obinutuzumab) Prior Authorization Form**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Criteria**

**For Initial Authorization: (continued)**

**1. Please indicate the diagnosis and information:**

**Follicular Lymphoma (FL)**

A. Will obinutuzumab be used for any of the following for members with Grade 1 or 2 disease:

i. Stage I ( $\geq 7$ cm)? Yes  No

ii. Contiguous Stage II ( $\geq 7$ cm)? 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

iii. Bendamustine? 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

**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

C. Will obinutuzumab be used in combination with lenalidomide or bendamustine? Yes  No

**Other:** \_\_\_\_\_

Additional Information: \_\_\_\_\_

**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_

2. Does the member have any evidence of progressive disease while on obinutuzumab? Yes  No

3. Has the member experienced adverse drug reactions related to obinutuzumab therapy? Yes  No

If yes, please specify adverse reactions: \_\_\_\_\_

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**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.*

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