

Monjuvi® (tafasitamab-cxix) 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:** **Diffuse Large B-Cell Lymphoma (DLBCL)**A. Is disease relapsed or refractory? Yes No B. Will tafasitamab-cxix be used in combination with lenalidomide? Yes No C. Is member eligible for autologous stem cell transplant? Yes No D. Is member a candidate for CAR T-cell therapy? Yes No **Other:** _____**Additional Information:** _____
_____**For Continued Authorization:**

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on tafasitamab-cxix? Yes No

3. Has the member experienced adverse drug reactions related to tafasitamab-cxix 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.****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.*

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.

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