OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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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:
   - ☐ **Lymphoma**
     - A. Is diagnosis low grade B-cell non-Hodgkin's lymphoma (NHL) or follicular lymphoma? Yes☐ No☐
     - B. Is disease relapsed or refractory? Yes☐ No☐
     - C. Is disease previously untreated follicular NHL achieving partial or complete response to first-line chemotherapy? Yes☐ No☐
     - D. Will ibritumomab tiuxetan be used in combination with rituximab? Yes☐ No☐
     - E. Is member new to treatment with ibritumomab tiuxetan? Yes☐ No☐
   - ☐ **Other:**_____

*****Please note: Zevalin is not recommended by the National Comprehensive Cancer Network (NCCN). Requests must indicate the rationale for treatment and must be reviewed by an oncology specialist prior to approval.*****

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:*_____

Additional Information: _____

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.	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.*