PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Bexxar/Zevalin

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address: Address:	
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What drug is being prescribed?

☐ Bexxar ☐ Zevalin

Q2. What diagnosis is this drug being prescribed for?

☐ Non-Hodgkin's lymphoma (NHL)
☐ Other

Q3. Please provide ICD code(s) for diagnosis

Q4. Please indicate location of administration.

☐ Home
☐ Long Term Care (LTC) facility
☐ Physician office (drug from office stock - buy and bill)
☐ Physician office (drug from pharmacy with a prescription)

Q5. Does the patient present with CD20 antigen expressing Non-Hodgkin's Lymphoma?

☐ Yes ☐ No

Q6. Does the patient present with relapsed or refractory Non-Hodgkin's Lymphoma?

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☐ Yes ☐ No
Q7. Does the patient present with low grade follicular or transformed Non-Hodgkin's Lymphoma? ☐ Yes ☐ No
Q8. Does the patient present Rituximab-refractory Non-Hodgkin's Lymphoma? ☐ Yes ☐ No
Q9. Is the patient's bone marrow involvement less than 26%? ☐ Yes ☐ No
Q10. Does the patient have a platelet count greater than or equal to 100,000 cells/mm3? ☐ Yes ☐ No
Q11. Does the patient have a neutrophil count greater than or equal to 1,500 cells/mm3? ☐ Yes ☐ No
Q12. Additional Comments

_____ _____

Prescriber Signature Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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