



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.

Form with fields for Patient Name, Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Prescriber Name, Supervising Physician, Fax, Office Contact, NPI, Address, City, State ZIP, Specialty/facility name, and State Lic ID.

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. If you selected "other" in question 2, please provide documentation that use is consistent with a category 2A or higher recommendation per NCCN compendia or guidelines.
Q4. Please provide ICD code(s) for diagnosis
Q5. 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)



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Patient Name:	Prescriber Name: Supervising Physician:
Q6. Is the prescribing physician a SWHP-approved Interventional Radiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. For Bexxar, does the patient present with CD20-positive, relapsed or refractory, low-grade, follicular, or transformed NLH who has progressed during or after rituximab therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. For Bexxar, does the patient present with rituximab-refractory NHL? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. For Zevalin, does the patient present with relapsed or refractory, low-grade or follicular B-cell NHL? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. For Zevalin, does the patient present with previously untreated follicular NHL who achieve a partial or complete response to first-line chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Is the patient's bone marrow involvement less than or equal to 26%? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. Does the patient have a platelet count greater than or equal to 100,000 cells/mm ³ ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q13. Does the patient have a neutrophil count greater than or equal to 1,500 cells/mm ³ ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q14. Additional Comments	

Prescriber Signature

Date



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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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