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. If you selected "other" in question 2, please provide documentation that use is consistent with a category 1 recommendation per NCCN compendia or guidelines.

Q4. Please provide ICD code(s) for diagnosis

Q5. Is the patient a new start to therapy? If no, please provide start date.

☐ Yes ☐ No

Q6. 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?

☐ Yes ☐ No

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Q7. For Bexxar, does the patient present with rituximab-refractory NHL?

☐ Yes ☐ No

Q8. For Zevalin, does the patient present with relapsed or refractory, low-grade or follicular B-cell NHL?

☐ Yes ☐ No

Q9. For Zevalin, does the patient present with previously untreated follicular NHL who achieve a partial or complete response to first-line chemotherapy?

☐ Yes ☐ No

Q10. Is the patient's bone marrow involvement less than or equal to 26%?

☐ Yes ☐ No

Q11. Does the patient have a platelet count greater than or equal to 100,000 cells/mm3?

☐ Yes ☐ No

Q12. Does the patient have a neutrophil count greater than or equal to 1,500 cells/mm3?

☐ Yes ☐ No

Q13. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

☐ Pharmacy
☐ Individual prescriber
☐ Provider or specialty group
☐ Facility
☐ Other (please specify)

Q14. Provide name and NPI of the billing entity

Q15. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q16. Additional Comments

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____ ________________________________

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 a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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