SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Gazyva® (Obinutuzumab) Prior Authorization Form

Member Name: _____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

Physician billing (HCPCS code:_____)

Dose: _____ ***Regimen:*** _____ ***Start Date:***_____

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 (Initial approval will be for the duration of 6 months):

1. Will obinutuzumab be used as a single-agent? Yes☐ No☐
2. Will obinutuzumab be used as first-line therapy? Yes☐ No☐
3. Will obinutuzumab be used as second-line or subsequent therapy? Yes☐ No☐
4. Will obinutuzumab be used in combination with bendamustine? Yes☐ No☐
5. Please indicate the diagnosis and information:
   - ☐ Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)
     - A. Will obinutuzumab be used in combination with chlorambucil? Yes☐ No☐
     - B. Will obinutuzumab be used in relapsed or refractory disease? Yes☐ No☐
   - ☐ Follicular Lymphoma (FL)
     - A. Will obinutuzumab be used for any of the following for members with Grade 1 or 2 disease:
       - i. Stage I (≥7cm)? Yes☐ No☐
       - ii. Contiguous Stage II (≥7cm)? Yes☐ No☐
       - iii. Noncontiguous Stage II, Stage III, or Stage IV? Yes☐ No☐
     - B. Will obinutuzumab be used in combination with any of the following:
       - i. CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone)? Yes☐ No☐
       - ii. CVP (cyclophosphamide, vincristine, and prednisone)? Yes☐ No☐
     - C. Will obinutuzumab be used as maintenance therapy? Yes☐ No☐
   - ☐ Gastric or Nongastric Mucosa-Associated Lymphoid Tissue (MALT) Lymphoma, Nodal or Splenic Marginal Zone Lymphoma (MZL)
     - A. Is the member refractory to a rituximab regimen? Yes☐ No☐
     - B. Will obinutuzumab be used as maintenance therapy as second-line consolidation or extended dosing? Yes☐ No☐
   - ☐ If diagnosis is not listed above, please indicate diagnosis: _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on obinutuzumab? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to obinutuzumab 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.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:
University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4