SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Drug Requested: Zevalin® (ibritumomab tiuxetan, Yttrium Y-90) **IV (A9543)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Quantity Limits:

A. Length of Authorization

- Coverage will be provided for one administration and may **NOT** be renewed

B. Max Units (per dose and over time) [HCPCS Unit]:

- 1 billable unit [up to 40 millicuries; 1 billable unit = 40 mCi]

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Approval Criteria – Coverage cannot be renewed

❑ Member is at least 18 years of age

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- ❑ Requesting provider is an oncologist
- ❑ **For female members of reproductive potential,** a negative pregnancy test has been confirmed
- ❑ Pre-treatment measurement of member's platelet level has been provided, and is **NOT** < 100,000 cells/mm^3
- ❑ Member has adequate marrow cellularity of > 15%
- ❑ Member's medical condition has < 25% involvement of lymphoma in bone marrow
- ❑ Requested medication will be used as a single agent following two doses of rituximab
- ❑ Member must meet **ONE** of the following:
  - ❑ Member has a diagnosis of relapsed or refractory, low-grade or follicular B-cell non-Hodgkin lymphoma (NHL), **AND** has not been previously treated with ibritumomab
  - ❑ Member has a diagnosis follicular NHL, previously untreated, **AND** has achieved a partial or complete response to first-line chemotherapy
- ❑ Provider will follow the recommended dosage per weight and timeline indication detailed in the table below:

Indication	Dose

All Indications	• Administer rituximab 250 mg/m^2 Day 1; repeat dose on Day 7, 8, or 9
	• Within 4 hours of the second dose of rituximab, administer ibritumomab intravenously as follows:
	  ○ Normal platelet count: 0.4 mCi/kg (14.8 MBq/kg)
	  ○ Relapsed/refractory & platelets 100,000 – 149,000/mcL: 0.3 mCi/kg (11.1 MBq/kg)
	• Do not exceed the maximum dose of 32.0 mCi (11.84 MBq)

Reauthorization Criteria – Coverage cannot be renewed

Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy - PropriumRx**

For urgent reviews: Practitioner should call Sentara Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.