BlueCross BlueShield Federal Employee Program.

GAZYVA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Gazyva (obinutuzumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 2**
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑ Brand ❑ Generic
3. What is the patient's diagnosis?
   ❑ Chronic lymphocytic leukemia (CLL) **OR** ❑ Small lymphocytic lymphoma (SLL)
   a. Is the patient's leukemia/lymphoma CD20-positive? ❑Yes ❑No
   b. Is this medication being used in combination with acalabrutinib (Calquence)? ❑Yes ❑No
   c. Is this medication being used as first-line therapy? ❑Yes ❑No
   d. Has the patient had an inadequate response or intolerance to purine analog? ❑Yes ❑No
   e. Does the patient have relapsed or refractory disease? ❑Yes***** ❑No
   ****If YES***, is this medication being used as a single agent? ❑Yes ❑No

   ❑ Follicular lymphoma (FL)
   a. Does patient have stage II bulky, III or IV follicular lymphoma? ***Please select answer below:***
   ❑**Yes**: Will this medication be used in combination with chemotherapy during the initial 6 cycles of treatment followed by use as monotherapy? ❑Yes ❑No
   ❑**No**: Please answer the following questions:
   i. Does the patient have relapsed or refractory follicular lymphoma? ❑Yes ❑No
   ii. Has the patient received two or more lines of systemic therapy? ❑Yes***** ❑No
   ****If YES***, will this medication be used in combination with Brukinsa (zanubrutinib)? ❑Yes ❑No
   iii. Is the patient relapsed or refractory to a rituximab-containing regimen? ❑Yes***** ❑No
   ****If YES***, will this medication be used in combination with bendamustine during the initial 6 cycles of treatment followed by use as monotherapy? ❑Yes ❑No

   ❑ Gastric or Nongastric MALT lymphoma **OR** ❑ Nodal Marginal Zone Lymphoma **OR** ❑ Splenic Marginal Zone lymphoma
   a. Is the patient relapsed or refractory to a rituximab-containing regimen? ❑Yes ❑No
   b. Will Gazyva be used in combination with bendamustine during the initial 6 cycles of treatment followed by use as monotherapy? ❑Yes ❑No

   ❑ Other ***(please specify)***: _____
4. Has the patient been screened or will be screened for hepatitis B prior to the initiation of therapy? ❑Yes***** ❑No
   ****If YES***, please answer the following questions:
   a. Has the hepatitis B virus infection been ruled out? ❑Yes ❑No
   b. Will the patient continue to be monitored during therapy if they are positive for hepatitis B? ❑Yes ❑No
5. Does the patient have any active infections? ❑Yes ❑No
6. Will the patient be monitored for signs and symptoms of progressive multifocal leukoencephalopathy (PML)? ❑Yes ❑No

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Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Gazyva (obinutuzumab)

***Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑ Brand ❑ Generic

3. What is the patient's diagnosis?
   ❑ Chronic lymphocytic leukemia (CLL)
      a. Is the patient's leukemia CD20-positive? ❑Yes ❑No
   ❑ Small lymphocytic lymphoma (SLL)
      a. Is the patient's lymphoma CD20-positive? ❑Yes ❑No
   ❑ Follicular lymphoma (FL)
   ❑ Gastric or Nongastric MALT lymphoma
   ❑ Nodal Marginal Zone Lymphoma
   ❑ Splenic Marginal Zone lymphoma
   ❑ Other **(*please specify*)**: _____

4. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No

5. Does the patient have any active infections? ❑Yes ❑No

6. Will the patient be monitored for signs and symptoms of progressive multifocal leukoencephalopathy (PML)? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times***.