



Arzerra® (ofatumumab)

PRIOR AUTHORIZATION REQUEST FORM

For authorization, **please answer each question, include patient chart notes to document clinical information, and fax this form back to the PEHP Prior Authorization Department at (801) 245-7774** or mail to: PEHP Pharmacy services, 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization questions, you may phone the PEHP Customer Service at (801) 366-7551.

| | | |
|----------------|--------------------|------------------|
| 1. Date: | 2. Patient Name: | 3. ID #: |
| 4. D.O.B: | 5. Physician: | 6. Office Phone: |
| 7. Office Fax: | 8. Office Contact: | 9. Dose Request: |
| 10. Sex: | 11. Weight: | |

Authorization is requested from: _____ to _____
Not to exceed 8 months for initial therapy.

| Question | Yes | No | Comments/Notes |
|---|-----|----|---|
| 12. Is the prescribing provider a board-certified oncologist? | | | |
| 13. Is the patient 18 years of age or older? | | | |
| 14. Select the diagnosis of the patient: <input type="checkbox"/> Chronic Lymphocytic Leukemia (CLL) <input type="checkbox"/> Other* (list indication): _____ | | | *Include clinical studies or articles to support the use of Arzerra® if you listed a non-FDA approved indication. |
| 15. Which chemotherapy agents or regimens has the patient tried and failed? _____ | | | |
| 16. Has the patient received previous therapy with Arzerra®? | | | |
| 17. If 'yes' to 16, has the patient shown clinical improvement from the pre-treatment report by showing no progression of disease? | | | Documentation is required. |
| 18. Source of Medication (Please select one): <input type="checkbox"/> Accredo <input type="checkbox"/> Physician (Bill by J-code) | | | If no selection is made, Accredo must be used |
| 19. Physician's Signature: _____ | | | |

PEHP USE ONLY

Site of approval: Accredo, Approved Home Health, or Medical

J-code: J9302 100mg/5ml

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