



**Lunsumio™ (Mosunetuzumab-axgb) Prior Authorization Form**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Drug Information**

Physician billing (HCPCS code: \_\_\_\_\_) Start Date (or date of next dose): \_\_\_\_\_  
Dose: \_\_\_\_\_ Regimen: \_\_\_\_\_

**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:**

1. Please indicate the diagnosis and information:

**Follicular Lymphoma (FL)**

a. Does member have relapsed or refractory disease after  $\geq 2$  lines of systemic therapy?  
Yes \_\_\_ No \_\_\_

**If diagnosis is not listed above, please indicate diagnosis:**

\_\_\_\_\_

Additional Information: \_\_\_\_\_

**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_

2. Does member have any evidence of progressive disease while on mosunetuzumab-axgb therapy?  
Yes \_\_\_ No \_\_\_

3. Has the member experienced any adverse drug reactions related to mosunetuzumab-axgb therapy?  
Yes \_\_\_ No \_\_\_

a. If yes, please specify adverse reactions: \_\_\_\_\_

Additional information: \_\_\_\_\_

**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. Failure to complete this form in full will result in processing delays. Please do not send in chart notes. Specific information will be requested if necessary.*

**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

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