OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Gazyva® (obinutuzumab) Prior Authorization Form

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

Drug Information

☐ **Physician billing (HCPCS code:_____)** ☐ **Pharmacy billing (NDC:_____)**

Dose: _____ Regimen: _____ Start Date (or date of next dose): _____

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. 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. Please indicate the diagnosis and information:

☐ **Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)**

A. Will obinutuzumab be used in combination with one of the following? Yes☐ No☐
acalabrutinib☐ bendamustine☐ chlorambucil☐ ibrutinib☐ venetoclax☐ (select one, if applicable)

i. If applicable, please completely fill out and submit the Calquence® (acalabrutinim) Prior Authorization Form (Pharm-125), the Imbruvica® (ibrutinib) Prior Authorization Form (Pharm-101) or the Venclexta® (venetoclax) Prior Authorization Form (Pharm-102) that is available on the OHCA website: www.okhca.org/rxforms.

B. Will obinutuzumab be used in relapsed or refractory disease? Yes☐ No☐

C. Is there a del(17p)/TP53 mutation? Yes☐ No☐

☐ **Diffuse Large B-Cell Lymphoma (DLBCL)**

A. Is diagnosis relapsed or refractory diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including large B-cell lymphoma (LBCL) arising from follicular lymphoma? Yes☐ No☐

B. Will obinutuzumab be used as lymphoid depletion pretreatment prior to glofitamab? Yes☐ No☐

i. If yes, please completely fill out and submit the Columvi™ (glofitamab-gxbm) Prior Authorization Form (Pharm-250) that is available on the OHCA website: www.okhca.org/rxforms.

☐ **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☐

C. Will obinutuzumab be used in combination with lenalidomide or bendamustine? Yes☐ No☐

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

CONFIDENTIALITY NOTICE

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

Criteria

For Initial Authorization: *(continued)*

1. Please indicate the diagnosis and information:

☐ **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☐
   iii. Bendamustine? Yes☐ No☐

C. Will obinutuzumab be used as maintenance therapy? Yes☐ No☐

D. Will obinutuzumab be used as third-line or subsequent therapy in members with no response, relapsed, or progressive disease? Yes☐ No☐

E. Will obinutuzumab be used in combination with zanubrutinib? Yes☐ No☐

☐ **Lupus Nephritis (LN)**

A. Does member have active LN and is receiving standard therapy? Yes☐ No☐

B. Has member had an inadequate response to any of the following medications appropriate to member's disease state? Check all that apply:
   ☐ High-dose oral corticosteroids
   ☐ Azathioprine
   ☐ Mycophenolate
   ☐ Cyclophosphamide
   ☐ Hydroxychloroquine/chloroquine

C. Will obinutuzumab be used in combination with other biologic therapies (e.g., anifrolumab, belimumab)? Yes☐ No☐

☐ **Other:** _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose:_____
2. Does the member have any evidence of progressive disease while on obinutuzumab? Yes☐ No☐
3. Has the member experienced 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. *Failure to complete this form in full will result in processing delays.*

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