OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Monjuvi® (tafasitamab-cxix) 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:**

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

A. Is disease relapsed or refractory? Yes☐ No☐
B. Will tafasitamab-cxix be used in combination with lenalidomide? Yes☐ No☐
C. Is member eligible for autologous stem cell transplant? Yes☐ No☐
D. Is member a candidate for CAR T-cell therapy? Yes☐ No☐

☐ **Follicular Lymphoma (FL)**

A. Is disease classic FL? Yes☐ No☐
B. Will tafasitamab-cxix be used as second line or later line of therapy (no response, relapsed, or progressive disease)? Yes☐ No☐
C. Will tafasitamab-cxix be used in combination with lenalidomide and rituximab? Yes☐ No☐
D. Has member received at least 1 prior systemic therapy including an anti-CD20 monoclonal antibody? Yes☐ No☐

☐ **Other:** _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on tafasitamab-cxix? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to tafasitamab-cxix 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. *Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*