State of Oklahoma
SoonerCare
Lunsumio® & Lunsumio VELO™ (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 ≥2 lines of systemic therapy?
        Yes ☐ No ☐
   - ☐ **Other:** _____

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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