Chemotherapy: Lymphoid Leukemia Drugs

Erwinaze (asparaginase erwinia chrysanthemi) J9019, Asparaginase NOS J9020, Rylaze (asparaginase) J9021, Treanda/Bendeka/Belrapzo (bendamustine HCl) J9033/J9034/J9036, Asparlas (Calaspargase Pegol-mknl) J9118, Synribo (omacetaxine mepesuccinate) J9262, Oncaspar (pegaspargase) J9266, Gazyva (obinutuzumab) J9301, Arzerra/Kesimpta (ofatumumab) J9302, Vivimusta (bendamustine) J9056

Prior Authorization Request

Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Oncology: NSCLC Meds PA

Drug Name(s):

ARZERRA
BENDEKA
ERWINAZE
GAZYVA
KESIMPTA
ONCASPAR
TREANDA
RYLAZE
BELRAPZO
ASPARLAS
SYNRIBO
ASPARAGINASE NOS
VIVIMUSTA
BENDAMUSTINE

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Prescribed by, or in consultation with an oncologist or other cancer specialist related to the diagnosis.
3. Drug is being used appropriately per CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
4. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

Cannot be prescribed for experimental or investigational use.

Prescriber Restrictions:

Oncologist or other cancer specialist

Coverage Duration:

New Start: Approval will be for 6 months
Continuation: Approval will be for 12 months

FDA Indications:

Arzerra, Kesimpta

- Chronic lymphoid leukemia, Extended treatment for patients in complete or partial response after at least 2 lines of therapy for recurrent or progressive disease
- Chronic lymphoid leukemia, Previously untreated, in combination with chlorambucil
- Chronic lymphoid leukemia, Refractory to fludarabine and alemtuzumab
- Chronic lymphoid leukemia, Relapsed, in combination with fludarabine and cyclophosphamide
- Relapsing remitting multiple sclerosis

Belrapzo, Bendeka, Treanda

- Chronic lymphoid leukemia
- Non-Hodgkin's lymphoma, Indolent B-cell, refractory to rituximab or rituximab-containing regimens

Gazyva

- Chronic lymphoid leukemia, Previously untreated, in combination with chlorambucil
- Follicular lymphoma, After relapse, or those who are refractory to a rituximab-containing regimen, in combination with bendamustine followed by obinutuzumab monotherapy

- Follicular lymphoma, In combination with chemotherapy followed by obinutuzumab monotherapy, in previously untreated stage II bulky, III, or IV disease in those with at least a partial response to combination therapy

Synribo

- Chronic myeloid leukemia, Chronic or accelerated phase with resistance to or intolerance of 2 or more tyrosine kinase inhibitors

Asparlas

- Acute lymphoid leukemia, As part of a chemotherapy regimen

Erwinaze

- Acute lymphoid leukemia, In combination with other chemotherapeutic agents in patients with hypersensitivity to E coli-derived asparaginase

Oncaspar

- Acute lymphoid leukemia, First-line, in combination with other agents
- Acute lymphoid leukemia, In combination with other agents in patients with hypersensitivity to L-asparaginase

Rylaze, Asparaginase

- Acute lymphoid leukemia, In combination with other chemotherapy agents; in patients who have developed E. coli-derived asparaginase hypersensitivity
- Lymphoblastic lymphoma, In combination with other chemotherapy agents; in patients who have developed E. coli-derived asparaginase hypersensitivity

Vivimusta

- Chronic lymphoid leukemia
- Non-Hodgkin's lymphoma, Indolent B-cell, refractory to rituximab or rituximab-containing regimens

Off-Label Uses:

Arzerra, Kesimpta

- Waldenstrom macroglobulinemia

Belrapzo, Bendeka, Treanda

- Metastatic breast cancer
- Multiple myeloma
- Non-Hodgkin's lymphoma
- Waldenstrom macroglobulinemia, In combination with rituximab
- Amyloidosis, relapsed or refractory, combination with dexamethasone
- Mantle cell lymphoma, previously untreated, transplant ineligible, in combination with rituximab

Oncaspar

- Acute lymphoid leukemia
- Extranodal NK/T-cell lymphoma, nasal type

Vivimusta

- AL amyloidosis, Relapsed or refractory, combination therapy with dexamethasone
- Cold agglutinin disease, chronic, In combination with rituximab
- Mantle cell lymphoma, Previously untreated, transplant ineligible, in combination with rituximab
- Metastatic breast cancer
- Multiple myeloma
- Non-Hodgkin's lymphoma
- Non-Hodgkin's lymphoma, Large B-cell, relapsed or refractory, as lymphodepleting chemotherapy prior to tisagenlecleucel
- Waldenstrom macroglobulinemia, In combination with rituximab

Age Restrictions:

Azerra, Bendeka, Gazyva, Kesimpta, Treanda, Vivimusta: Safety and effectiveness not established in pediatric patients
Rylaze: 1 month or older

Other Clinical Considerations:

Cancer diagnoses: Criteria as per NCCN or other FDA-approved cancer related guidelines.

Resources:

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