

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

Drug Information

Physician billing (HCPCS code: _____)

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 (Initial approval will be for the duration of 6 months):

1. Will ofatumumab be used as a single-agent? Yes ___ No ___
2. Please indicate the diagnosis and information:
 - Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)
 - A. Will ofatumumab be used as first-line treatment? Yes ___ No ___
 - B. Will ofatumumab be used in combination with chlorambucil or bendamustine? Yes ___ No ___
 - C. Will ofatumumab be used in relapsed or refractory disease? Yes ___ No ___
 - D. Will ofatumumab be used in combination with fludarabine and cyclophosphamide? Yes ___ No ___
 - E. Will ofatumumab be used as maintenance therapy as second-line extended dosing following complete or partial response to relapsed or refractory therapy? Yes ___ No ___
 - Waldenström's Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma
 - A. Will ofatumumab be used for previously treated disease that did not respond to primary therapy? Yes ___ No ___
 - B. Will ofatumumab be used for progressive or relapsed disease? Yes ___ No ___
 - C. Will ofatumumab be used as combination therapy? Yes ___ No ___
 - D. Is the member rituximab-intolerant? Yes ___ No ___
 - If diagnosis is not listed above, please indicate diagnosis: _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on ofatumumab? Yes ___ No ___
3. Has the member experienced any adverse drug reactions related to ofatumumab therapy? Yes ___ No ___
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. 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:

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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