



Monjuvi

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ kg
Patient Height: _____ cm

Please indicate the place of service for the requested drug:

- Ambulatory Surgical (POS Code 24)
- Off Campus Outpatient Hospital (POS Code 19)
- Office (POS Code 11)
- Home (POS Code 12)
- On Campus Outpatient Hospital (POS Code 22)

Drug Information:

Strength/Measure _____ *Units* ml Gm mg ea Un
Directions(sig) _____ *Route of administration* _____
Dosing frequency _____

What is the ICD-10 code? _____

Criteria Questions:

- What is the diagnosis?
 - Human immunodeficiency virus (HIV)-Related B-cell lymphoma (including HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, HIV-related plasmablastic lymphoma and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma), *Continue to 2*
 - Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, *Continue to 2*
 - Follicular lymphoma, *Continue to 2*
 - Monomorphic post-transplant lymphoproliferative disorders (PTLD) (B-cell type), *Continue to 2*

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Monjuvi SGM 4056-A – 01/2024.

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Diffuse large B-cell lymphoma (DLBCL) (including DLBCL arising from low grade lymphoma and DLBCL not otherwise specified, *Continue to 2*

High-grade B-cell lymphomas (HGBLs), *Continue to 2*

Other, please specify. _____, *No further questions*

2. Is the patient currently receiving treatment with the requested medication?

Yes, *Continue to 3*

No, *Continue to 6*

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

Yes, *Continue to 4*

No, *Continue to 4*

4. Has the patient completed 12 or more cycles in combination with lenalidomide (for up to a maximum of 12 cycles)?

Yes, *Continue to 5*

No, *No Further Questions*

5. Will the requested medication be used as monotherapy?

Yes, *No Further Questions*

No, *No Further Questions*

6. What is the clinical setting in which the requested medication will be used?

Relapsed disease, *Continue to 7*

Refractory disease, *Continue to 7*

Other, please specify. _____, *Continue to 7*

7. Is the patient eligible for an autologous stem cell transplant?

Yes, *Continue to 8*

No, *Continue to 8*

8. Will the requested medication be used in combination with lenalidomide (for up to a maximum of 12 cycles)?

Yes, *No Further Questions*

No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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