JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Polivy

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* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

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

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

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

Criteria Questions:

1. What is the diagnosis?
   - ❑ Diffuse large B-cell lymphoma
   - ❑ High grade B-cell lymphoma
   - ❑ Mantle cell lymphoma
   - ❑ Monomorphic post-transplant lymphoproliferative disorders (B-cell type)
   - ❑ Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphomas (AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma)
   - ❑ Histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma
   - ❑ Histologic transformation of follicular lymphoma to diffuse large B-cell lymphoma without translocations of MYC and BCL2 and/or BCL6
   - ❑ Follicular lymphoma
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the patient currently receiving treatment with Polivy? ❑ Yes ❑ No *If No, skip to #6*
4. How many cycles of Polivy has the patient received in a lifetime? _____ cycles
5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions.*
6. What is the regimen request?
   - ❑ Polivy will be used as a single agent
   - ❑ Polivy will be used in combination with bendamustine only
   - ❑ Polivy will be used in combination with bendamustine and rituximab
   - ❑ Other
7. How many cycles of chemotherapy containing Polivy are planned? _____ cycles
8. What is the place in therapy the requested drug will be used? ❑ Initial ❑ Subsequent

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Diffuse large B-cell lymphoma, High-grade B-cell lymphoma

9. Has the member received at least two prior therapies? ❑ Yes ❑ No
10. Is the patient a candidate for transplant? ❑ Yes ❑ No

Section B: Mantle cell lymphoma, AIDS-related B-cell lymphomas (AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma), Follicular lymphoma

11. Has the member received at least two prior therapies? ❑ Yes ❑ No

Section C: Monomorphic post-transplant lymphoproliferative disorders (B-cell type), histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma, histologic transformation of follicular lymphoma to diffuse large B-cell lymphoma without translocations of MYC and BCL2 and/or BCL6

12. Has the member received at least two prior chemoimmunotherapies? ❑ Yes ❑ No

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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