State of Oklahoma
Oklahoma Health Care Authority

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Arzerra® (Ofatumumab) Prior Authorization Form

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.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.