State of Oklahoma SoonerCare
Monjuvi® (Tafasitamab-cxix)
Prior Authorization Form

OKLAHOMA Health Care Authority | SoonerSelect | aetna

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

Drug Information

Physician billing (HCPCS code: _____**)** ***Start Date (or date of next dose):*** _____

Dose: _____ ***Regimen:*** _____

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

1. Please indicate the diagnosis and information:

☐ **Diffuse Large B-Cell Lymphoma (DLBCL)**

A. Is disease relapsed or refractory? Yes☐ No☐

B. Will Monjuvi® (tafasitamab-cxix) be used in combination with lenalidomide? Yes☐ No☐

☐ **If answer is none of the above, please indicate diagnosis:** _____

Additional Information: _____

_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on tafasitamab-cxix? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to tafasitamab-cxix 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**.