OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Polivy® (Polatuzumab Vedotin-piiq) Prior Authorization Form

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

Drug Information

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

Dose:_____ Dosing 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 the diagnosis previously untreated DLBCL not otherwise specified or high-grade B-cell lymphoma? Yes☐ No☐
   i. If yes, does the member have an International Prognostic Index score of ≥2? Yes☐ No☐
   ii. Will polatuzumab vedotin be used in combination with rituximab, cyclophosphamide, doxorubicin, and prednisone (R-CHP)? Yes☐ No☐

B. Is the diagnosis relapsed/refractory DLBCL not otherwise specified or high-grade B-cell lymphoma? Yes☐ No☐
   i. If yes, has the member received at least 2 prior therapies? Yes☐ No☐
   ii. Will polatuzumab vedotin be used in combination with bendamustine and rituximab? Yes☐ No☐
   iii. If using without bendamustine, will member proceed to CAR-T therapy? Yes☐ No☐
   iv. Is member a candidate for transplant, or does member have the intention to proceed to transplant? Yes☐ No☐

☐ If diagnosis is not listed above, please indicate diagnosis:_____

Additional Information: _____

_____

_____

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.**

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

For Continued Authorization:

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

*If yes, please specify adverse reactions:*_____

_____

_____

_____

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. *Failure to complete this form in full will result in processing delays.*

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