OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Adcetris® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
- ❑ CD30-expressing mycosis fungoides (MF)
- ❑ Hodgkin lymphoma (HL)
- ❑ Primary cutaneous anaplastic large cell lymphoma (pcALCL)
- ❑ Systemic anaplastic large cell lymphoma (sALCL)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:
Is Adcetris prescribed by or in consultation with an oncologist/hematologist? ❑ **Yes** ❑ **No**

For CD30-expressing mycosis fungoides (MF) or primary cutaneous anaplastic large cell lymphoma (pcALCL), answer the following:
Has the patient had failure of at least one prior systemic therapy? ❑ **Yes** ❑ **No**

For Hodgkin lymphoma, answer the following:
Select if the patient has had previous failure to the following:
- ❑ Autologous hematopoietic stem cell transplant (auto-HSCT)
- ❑ At least two prior multi-agent chemotherapy regimens

Will Adcetris be used as post-auto-HSCT consolidation therapy? ❑ **Yes** ❑ **No**
Is the patient at high risk of relapse or progression? ❑ **Yes** ❑ **No**
Will Adcetris be used in combination with chemotherapy (e.g., doxorubicin, vinblastine, dacarbazine)? ❑ **Yes** ❑ **No**
Has the patient had previously untreated Stage III or IV disease? ❑ **Yes** ❑ **No**

For systemic anaplastic large cell lymphoma (sALCL), answer the following:
Does the patient have failure to at least one prior multi-agent chemotherapy regimen? ❑ **Yes** ❑ **No**

Reauthorization:
Does the patient show evidence of disease progression while on Adcetris therapy? ❑ **Yes** ❑ **No**
Does the patient show evidence of peripheral neuropathy? ❑ **Yes** ❑ **No**
If the patient has symptoms of new or worsening peripheral neuropathy, has the Adcetris dose been adjusted (e.g., held dose, lowered dose)? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.