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

Zydelig® 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:

- ❑ Relapsed chronic lymphocytic leukemia (CLL)
- ❑ Relapsed follicular B-cell non-Hodgkin lymphoma
- ❑ Relapsed small lymphocytic lymphoma (SLL)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Provider's Specialty:

Is Zydelig prescribed by or in consultation with an oncologist/hematologist? ❑ **Yes** ❑ **No**

For relapsed chronic lymphocytic leukemia (CLL), answer the following:

Has the patient relapsed on at least one prior therapy (e.g., purine analogues [fludarabine, pentostatin, cladribine], alkylating agents [chlorambucil, cyclophosphamide], or monoclonal antibodies [rituximab])? ❑ **Yes** ❑ **No**

Will Zydelig be used in combination with Rituxan (rituximab)? ❑ **Yes** ❑ **No**

Is the patient a candidate for Rituxan (rituximab) monotherapy due to presence of other comorbidities (e.g., coronary artery disease, peripheral vascular disease, diabetes mellitus, pulmonary disease [COPD], etc.)? ❑ **Yes** ❑ **No**

For relapsed follicular B-cell non-Hodgkin lymphoma, answer the following:

Has the patient relapsed on at least two prior systemic therapies (e.g., rituximab, alkylating agents [cyclophosphamide, chlorambucil], anthracyclines [doxorubicin, daunorubicin], purine analogs [fludarabine])? ❑ **Yes** ❑ **No**

For relapsed small lymphocytic lymphoma (SLL), answer the following:

Has the patient relapsed on at least two prior systemic therapies (e.g., rituximab, alkylating agents [cyclophosphamide, chlorambucil], anthracyclines [doxorubicin, daunorubicin], purine analogs [fludarabine])? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following question:

Does the patient show evidence of progressive disease while on Zydelig therapy? ❑ **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.

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