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

Gazyva® 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:

❑ Chronic lymphocytic leukemia (CLL)
❑ Follicular lymphoma (FL)
❑ Small lymphocytic lymphoma (SLL)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is this request for continuation of prior Gazyva therapy? ❑ **Yes** ❑ **No**
Has the patient used Gazyva within the last 120 days? ❑ **Yes** ❑ **No**
Is Gazyva prescribed by or in consultation with a hematologist/oncologist? ❑ **Yes** ❑ **No**

For chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL), answer the following:

Will Gazyva be used in combination with chlorambucil? ❑ **Yes** ❑ **No**
Has the patient previously been treated for CLL? ❑ **Yes** ❑ **No**

For follicular lymphoma, answer the following:

Will Gazyva be used as part of second-line extended dosing? ❑ **Yes** ❑ **No**
Will Gazyva be used in combination with bendamustine? ❑ **Yes** ❑ **No**
If "yes" to the above question, will treatment be followed by Gazyva monotherapy? ❑ **Yes** ❑ **No**
Has the patient relapsed or is refractory to a rituximab-containing regimen? ❑ **Yes** ❑ **No**
Does the patient have stage II bulky, III, or IV follicular lymphoma? ❑ **Yes** ❑ **No**
Has the patient been treated with prior therapy? ❑ **Yes** ❑ **No**
Will Gazyva be used in combination with chemotherapy until the patient has at least achieved partial remission? ❑ **Yes** ❑ **No**
If "yes" to the above question, will treatment be followed by Gazyva monotherapy? ❑ **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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.

Office use only: Gazyva_CMS_2019Jan-W