OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
Adcetris® (Brentuximab Vedotin) Prior Authorization Form

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

Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization:

1. Please indicate the requested information:
   - A. Will brentuximab vedotin be used as a single-agent? Yes☐ No☐
   - B. Will brentuximab vedotin be used as a primary treatment? Yes☐ No☐
   - C. Will brentuximab vedotin be used in relapsed/refractory disease? Yes☐ No☐
   - D. Will brentuximab vedotin be used in combination with cyclophosphamide, doxorubicin, and prednisone (CHP)? Yes☐ No☐
2. Please indicate the diagnosis and information:

☐ **Anaplastic Large Cell Lymphoma (ALCL), Primary Cutaneous**
- A. Does member have multifocal lesions or regional nodes? Yes☐ No☐

☐ **Anaplastic Large Cell Lymphoma (ALCL), Systemic**
- A. Is the diagnosis previously untreated? Yes☐ No☐
- B. Has member received one or more lines of therapy? Yes☐ No☐

☐ **Adult Classical Hodgkin Lymphoma (age ≥18 years)**
- A. Is disease previously untreated Stage III or IV? Yes☐ No☐
- B. Will brentuximab vedotin be used in combination with doxorubicin, vinblastine, and dacarbazine? Yes☐ No☐
- C. Is member a non-autologous stem cell transplant (SCT) candidate with failure of 2 or more multi-agent chemotherapy regimens? Yes☐ No☐
- D. Has member failed autologous SCT? Yes☐ No☐
- E. Has brentuximab vedotin been previously used in combination with nivolumab, bendamustine, or multi-agent chemotherapy? Yes☐ No☐
- F. Does member have consolidation after autologous SCT with a high risk of relapse or progression? Yes☐ No☐

☐ **Pediatric Classical Hodgkin Lymphona (cHL), (age 2-21 years)**
- A. Is cHL previously untreated? Yes☐ No☐
- B. Is cHL Stage IIB with bulky disease, Stage IIIB, or Stage IV per Ann Arbor Staging System? Yes☐ No☐
- C. Will brentuximab vedotin be used in combination with doxorubicin, vincristine, etoposide, prednisone, and cyclophosphamide (AVE-PC)? Yes☐ No☐

Please complete and return all pages. Failure to complete all pages will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® 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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Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

2. Please indicate the diagnosis and information, continued:

☐ **Primary Cutaneous Lymphomas – Mycosis Fungoides (MF)/Sézary Syndrome (SS)**

☐ **Diffuse Large B-Cell Lymphoma (DLBCL) or High Grade Lymphoma**
- A. Is disease CD30+? Yes☐ No☐
- B. Is member a non-autologous stem cell transplant (SCT) candidate? Yes☐ No☐
- C. Has member transformed to DLBCL from follicular lymphoma or marginal zone lymphoma and received 2 or more lines of therapy for indolent or transformed disease? Yes☐ No☐

☐ **Peripheral T-Cell Lymphoma (PTCL)**
- A. Previously untreated CD30+ disease? Yes☐ No☐
- B. Has member received one or more lines of therapy? Yes☐ No☐

☐ **Adult T-Cell Leukemia/Lymphoma**
- A. Is disease CD30+? Yes☐ No☐
- B. Is member a nonresponder to first-line therapy with chronic/smoldering subtype? Yes☐ No☐
- C. Will brentuximab vedotin be used for first-line therapy for acute or lymphoma subtype? Yes☐ No☐
- D. Will brentuximab vedotin be used for continued treatment in responders to first-line therapy for acute or lymphoma subtype? Yes☐ No☐
- E. Has member received one or more lines of therapy? Yes☐ No☐

☐ **T-Cell Lymphoma, Extranodal NK/T-Cell Lymphoma, Nasal Type**
- A. Is disease CD30+? Yes☐ No☐
- B. Is disease relapsed/refractory following additional therapy with an alternate combination chemotherapy regimen not previously used? 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 brentuximab vedotin? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to brentuximab vedotin therapy? Yes☐ No☐

If yes, please specify adverse reactions: _____

Additional Information: _____

_____

Please complete and return all pages. Failure to complete all pages will result in processing delays.
Please do not send in chart notes. Specific information will be requested if necessary.

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.

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