OKLAHOMA Health Care Authority

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State of Oklahoma
SoonerCare
Zynlonta® (Loncastuximab Tesirine-lpyl)
Prior Authorization Form

***Member Name:*______________________ *Date of Birth:*____________ *Member ID#:*________________**

Drug Information

❑Physician billing (HCPCS code:___________) ❑Pharmacy billing (NDC:______________________)

***Start Date (or date of next dose):*______________ *Dose:*____________________**

***Dosing Regimen: Cycles 1 & 2*______________________ Subsequent Cycles:______________________**

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. Please select 1 of the following:
    - _____ DLBCL not otherwise specified
    - _____ DLBCL arising from low grade lymphoma
    - _____ High-grade B-cell lymphoma
    - _____ Other, please specify: ________________________
  - B. Is disease relapsed or refractory after 2 or more lines of systemic therapy? Yes____ No____
  - C. Was previous CD19-directed therapy was used? Yes____ No____
    - i. If yes, does the member have a biopsy that shows CD19 protein expression after completion of the CD19-directed therapy? Yes___ No____
      - 1. If yes, please provide biopsy results.
  - D. Please provide a patient-specific, clinically significant reason why tafasitamab in combination with lenalidomide is not appropriate for the member:

    ____

- ❑ **If diagnosis is not listed of the above, please indicate diagnosis:**_________________________

Additional Information:____

For Continued Authorization:

1. Date of last dose:_____________________________
2. Does the member have any evidence of progressive disease while on Zynlonta®? Yes____ No____
3. Has the member experienced adverse drug reactions related to Zynlonta® 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.*

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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