ATRIO HEALTH PLANS

Zevalin Y-90

Zevalin Y-90 (Ibritumomab Tiuxetan) A9543

Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ Relapsed or Refractory Low-Grade or Follicular B-Cell Non-Hodgkin Lymphoma (NHL)

- ☐ Patient is 18 years or older
- ☐ Confirmed diagnosis of low-grade or follicular B-cell non-Hodgkin lymphoma
- ☐ Patient has relapsed or refractory disease following at least one prior systemic therapy (including rituximab)
- ☐ ECOG performance status 0-2
- ☐ Adequate bone marrow reserve (e.g., platelets ≥150,000/mm³, absolute neutrophil count ≥1,500/mm³)
- ☐ Bone marrow involvement ≤25%
- ☐ No prior stem cell transplant or external beam radiation to >25% of active bone marrow
- ☐ Prescribed by or in consultation with hematologist/oncologist
- ☐ Patient is enrolled in and will be managed according to Zevalin REMS program

☐ Previously Untreated Follicular NHL – Consolidation Following First-Line Chemotherapy

- ☐ Patient is 18 years or older
- ☐ Confirmed diagnosis of follicular non-Hodgkin lymphoma
- ☐ Patient has achieved partial or complete response to first-line chemotherapy (including rituximab)
- ☐ Consolidation therapy with Zevalin is planned as part of treatment regimen

☐ ECOG performance status 0-2
☐ Adequate bone marrow reserve (platelets ≥150,000/mm³, ANC ≥1,500/mm³)
☐ Bone marrow involvement ≤25%
☐ Prescribed by or in consultation with hematologist/oncologist
☐ Patient is enrolled in Zevalin REMS program

If not, please provide **clinical rationale** for formulary exception: _____
_____

☐ **Continuation Requests: (Clinical documentation required for all requests)**

☐ Patient had an **adequate response** or **significant improvement** while on this medication.
☐ Medical record documentation of positive response is included

If not, please provide clinical rationale for continuing this medication: _____
_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Zevalin Y-90 Prior Authorization

Drug Name(s):

ZEVALIN Y-90 **IBRITUMOMAB TIUXETAN**

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.
- Continuation Requests: Provider must verify continued clinical benefit in confirmatory trial(s).

Exclusion Criteria:

N/A

Prescriber Restrictions:

Hematologist, Oncologist or other related specialist

Coverage Duration:

Approval will be for 6 months

FDA Indications:

Zevalin Y-90

- Non-Hodgkin's lymphoma, Relapsed or refractory
- Non-Hodgkin's lymphoma, Untreated, after achieving a partial or complete response to first-line chemotherapy

Off-Label Uses:

N/A

Age Restrictions:

Safety and effectiveness in children have not been established

Other Clinical Consideration:

Serious infusion reactions, including fatalities, have occurred within 24 hours of rituximab infusion, an essential component of the ibritumomab tiuxetan therapeutic regimen. Most fatal infusion reactions (80%) occurred with the first rituximab infusion. Administration also results in severe and prolonged cytopenias in most patients. The ibritumomab tiuxetan therapeutic regimen should not be administered to patients with 25% or greater lymphoma marrow involvement and/or impaired bone marrow reserve. Severe cutaneous and mucocutaneous reactions, some with fatal outcome, can occur with therapy. The dose of Y-90 ibritumomab tiuxetan should not exceed the absolute maximum allowable dose of 32 millicurie (1184 megabecquerels)

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/PFDefaultActionId/evidencexpert.DoIntegratedSearch?SearchTerm=Zevalin%20Y-90&SearchFilter=filterNone#