Granite Alliance Insurance Company (PDP)

P.O. Box 899
SLC, UT 84110
Fax: 801-503-3880
Phone: 1-855-586-2573, TTY 711

MEDICARE PART D PRIOR AUTHORIZATION REQUEST

Gazyva™ (obinutuzumab)

□ **URGENT REQUEST** (Life Threatening) □ **NON-URGENT REQUEST** (Standard Review)

INDICATION: Chronic Lymphocytic Leukemia (CLL)

QUANTITY LIMIT: N/A

AUTHORIZATION PERIOD: 12 Months

MEDICATION INFORMATION

Medication Name _____ Strength _____
Quantity Requested Per Month _____ Diagnosis _____
Directions _____

MEMBER INFORMATION

Name _____
DOB __ __/__ __/__ __
Phone (__ __ __) __ __ __-__ __ __ __

MEMBER ID NUMBER

_____
Address _____
City _____
State _____ Zip _____

PRESCRIBER INFORMATION

Name _____
Phone (__ __ __) __ __ __-__ __ __ __ ext._____
Fax (__ __ __) __ __ __-__ __ __ __
Address _____
City _____
State _____ Zip _____
Date _____
Signature _____

This medication requires a B vs. D Determination. Please call 1-855-586-2573 in order to complete this determination.

Please check *Yes* or *No* and answer the following questions:			
1.	Is the prescriber an Oncologist or Hematologist?	□ Yes	□ No
2.	Does the patient have a diagnosis of Chronic Lymphocytic Leukemia (CLL)?	□ Yes	□ No
3.	Is the patient being treated in combination with chlorambucil?	□ Yes	□ No

*Authorization responses are faxed to the number listed on the form which should adhere to security standards for Personal Health Information. For quickest response, please ensure all requested information is included and complete.