P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth

PREAUTHORIZATION FORM

Adcetris™
(brentuximab vedotin)

Therapeutic use: Treatment of patients with Hodgkin lymphoma or systemic anaplastic large cell lymphoma after failure of previous treatment(s).
Quantity Limit: 1.8 mg/kg IV once every 3 weeks for a maximum of 16 cycles
Authorization Period: 12 months

Patient's name _____

Patient's ID# | | | | | | | | | | DOB | | | / | | | / | | | | |

ICD-9 | | | | | | | | | | | | _____

Physician's name_____

Physician's Ph# (| | |) | | | | - | | | | | Fax# | | | | - | | | | |

Physician's signature_____ Date signed | | | / | | | / | | | | |

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Is the prescriber an oncologist or hematologist?	❑ Yes	❑ No
	Hodgkin Lymphoma		
2.	Does the patient have histologically confirmed CD30-positive Hodgkin lymphoma?	❑ Yes	❑ No
2a.	Has the patient failed treatment with autologous stem cell transplant (ASCT)?	❑ Yes	❑ No
2c.	If the patient is not a candidate for ASCT, have they failed at least two prior multi-agent chemotherapy regimens? If so, please list regimens: Treatment Regimen / Date of therapy _____ / _____ _____ / _____ _____ / _____ _____ / _____	❑ Yes	❑ No
	Systemic Anaplastic Large Cell Lymphoma (sALCL)		
3.	Has the patient been diagnosed with sALCL?	❑ Yes	❑ No
3a.	Has the patient failed at least one prior multi-agent chemotherapy regimen? If so, please list regimen: Treatment Regimen / Dates of therapy _____ / _____ _____ / _____	❑ Yes	❑ No

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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Last Updated: 09/14/2011