HEALTH PLANS
UNIVERSITY OF UTAH

PHARMACY PRIOR AUTHORIZATION REQUEST FORM
LUNSUMIO™

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: Individual Exchange: 833-981-0214, Commercial Groups: 833-981-0213, MHC: 844-262-1560

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Lunsumio™ (mosunetuzumab-axgb)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does documentation show histologically confirmed diagnosis of relapsing or refractory follicular lymphoma grade 1, 2, or 3A?	☐	☐	**Please provide documentation**
2. Does the member have an Eastern Cooperative Oncology Group (ECOG) Performance status of 0 or 1?	☐	☐	**Please provide documentation**
3. Does documentation show no response or refractory to at least 2 lines of systemic therapy, including both of the following: • Anti-CD20 therapy • An alkylating containing regimen	☐	☐	**Please provide documentation**
4. Does the member have current or past central nervous system (CNS) involvement?	☐	☐	**Please provide documentation**
5. For females with reproductive potential: • Is there documentation of a negative pregnancy test prior to the start of therapy? • Has the member been counseled on the use of effective contraception during treatment and advised of the pregnancy risks associated with treatment?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member had a complete response based on imaging and bone marrow examination?	☐	☐	**Please provide documentation**

3. Does the member have a partial response on stable disease in response to treatment with Lunsumio™ after 8 cycles?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

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Policy: PHARM-M043
Origination Date: 03/01/2023
Reviewed/Revised Date: 03/15/2023
Next Review Date: 03/15/2024
Current Effective Date: 04/01/2023