Send completed form to:
Blue Shield of California
Fax: 1-855-895-3504

Adcetris
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

CARDHOLDER / PATIENT INFORMATION

Cardholder Name: ______________________________ / _____ / ______________________________
First MI Last

Patient Name: ______________________________ / _____ / ______________________________
First MI Last

Patient Address: ____
Street City State Zip

Patient Date of Birth: ____ / ____ / ____ Sex: M ____ F _____

R |_|_|_|_|_|_|_|_|
Cardholder Identification Number

PHYSICIAN COMPLETES

Adcetris (brentuximab vedotin)

NOTE: Form must be completed in its **entirety** for processing

1. What is the **diagnosis** for which Adcetris is being prescribed?
   - ☐ Hodgkin's lymphoma
   - ☐ Systemic anaplastic large cell lymphoma (ALCL)
   - ❑ **Other Diagnosis** ***(please specify):*** ____

2. Has the patient been receiving **Adcetris** therapy for at least **6 months** continuously, excluding samples? ❑Yes ❑No

❑**NO** – this would be the **INITIATION** of Adcetris therapy, please answer **the following** questions:

For diagnosis of Hodgkin's lymphoma:

a. Has the patient experienced a failure of an autologous hematopoietic stem cell transplant (auto-HSCT)? ❑Yes ❑No

b. If the patient is not a candidate for auto-HSCT has the patient experienced a treatment failure of at least two prior multi-agent chemotherapy regimens? ❑Yes ❑No

c. Is the patient at high risk of relapse or progression after an autologous hematopoietic stem cell transplantation? ❑Yes ❑No

For diagnosis of Systemic anaplastic large cell lymphoma (ALCL)

a. Has the patient failed at least one prior multi-agent chemotherapy regimen? ❑Yes ❑No

❑**YES – this would be the CONTINUATION of therapy**, please answer **the following** question:

a. Has the patient completed their 16 cycles of Adcetris treatment? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification.

Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer,

______________________________ (_____) ________________ (_____) ________________
Physician Name (Print Clearly) Phone Fax

______________________________ ________________ ________ ________
Street Address City State Zip

________________ ______________________________ ______ / ______ / ______
Prescriber's NPI Physician Signature Date