

- Without chromosomal deletion (17p)
 - Individual has had a short response (less than 2 years)
 - Younger than 70 years old
 - 70 years old or older without significant comorbidities
 - In combination with Fludarabine
 - Other: _____

- Individual has T-cell prolymphocytic leukemia (T-PLL)
- Other: _____

(2) Mycosis Fungoides (MF)/ Sezary's Syndrome (SS)

- Individual has Cutaneous T-cell lymphoma (Mycosis Fungoides (MF)/Sezary's Syndrome (SS))
- Other: _____

(3) Lymphoma

- Individual has non-Hodgkin's lymphoma (NHL)
 - Individual has advanced low-grade malignancy
 - Other: _____
- Individual has peripheral T-cell lymphoma
- Individual has Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma
 - Will be used as single agent salvage therapy
 - Disease does not respond to primary therapy
 - Progressive or relapsed disease
 - Other: _____
 - Other: _____
- Other: _____

(4) For Use in Transplantation

- Individual has undergone pancreas transplantation.
 - Will be used for induction and maintenance immunosuppression
 - Other: _____
- Individual has undergone renal transplantation.
 - Will be used for induction and maintenance immunosuppression
 - Other: _____
- For use with stem cell transplantation. If checked please check the following that apply:
 - Will be used as a component of the conditioning regimen
 - Individual has non-Hodgkin's lymphoma
 - Individual has acute myeloid leukemia (AML)
 - Allogeneic stem cell transplant
 - Other: _____
 - Other: _____
- Other: _____

(5) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

 Name & Title of Provider or Provider Representative Completing Form
 & attestation (Please Print)*

/ /
 Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.