Prior Authorization Request Form for
acalabrutinib (Calquence)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient GREATER THAN or EQUAL to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is Calquence being prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have pathologically confirmed relapsed or refractory mantle cell lymphoma (MCL), with documentation of monoclonal B cells that have a chromosome translocation t(11;14)(q13;q32) and/or overexpress cyclin D1 that has a short response duration to prior therapy (less than median progression free survival [PFS])?	☐ Yes Proceed to question **11**	☐ No Proceed to question **4**
4. Does the patient have a diagnosis of relapsed refractory therapy for chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)?	☐ Yes Proceed to question **5**	☐ No Proceed to question **7**
5. Does the patient have CLL/SLL with del(17p)/TP53 mutation?	☐ Yes Proceed to question **9**	☐ No Proceed to question **6**
6. Does the patient fit into any of the following categories? ○ Younger than 65 years of age ○ 65 years of age or older with significant comorbidities ○ Frail patient with significant comorbidities (not able to tolerate purine analogs)	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**

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7. Please provide the diagnosis.	_____ Proceed to question **8**	
8. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
9. Does the patient have evidence of a BTK C481S mutation?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Does the patient have prior ibrutinib-refractory disease?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**
11. Does the patient have significant cardiovascular disease such as uncontrolled or symptomatic arrhythmias, congestive heart failure, or myocardial infarction within 6 months of screening, or any Class 3 or 4 cardiac disease as defined by the New York Heart Association Functional Classification, or corrected QT interval (QTc) GREATER THAN 480 msec?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Will the patient be monitored for bleeding, infection, cardiac arrhythmias, and cytopenias?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. What is the patient's age/gender?	☐ **Male - Sign and date below** ☐ **Female of childbearing potential -** Proceed to question **14** ☐ **Female not of childbearing potential - Sign and date below**	
14. Has the patient been advised of the risk of significant fetal harm?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Is the patient breastfeeding?	☐ Yes Proceed to question **16**	☐ No **Sign and date below**
16. Has it been confirmed that patients will not breastfeed during treatment and for at least 2 weeks following cessation of treatment?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[08 April 2020]

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For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: