TRICARE Prior Authorization Request Form for
ibrutinib (Imbruvica)

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HEALTH PLANS
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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. **Does the prescriber acknowledge that Imbruvica capsules are more cost-effective for DoD than the Imbruvica tablets at the 140 and 280 mg strengths?**	☐ Acknowledged Proceed to question **2**	
2. **What is the requested medication?**	☐ Imbruvica capsules or suspension Proceed to question **6**	☐ Imbruvica tablets Proceed to question **3**
3. **What is the requested strength?**	☐ 140 or 280 mg Proceed to question **4**	☐ Other strength Proceed to question **6**
4. **Imbruvica capsules are more cost-effective for DoD than the Imbruvica tablets at the 140 and 280 mg strengths. Will the prescription be changed to the capsule formulation for these strengths?**	☐ Yes Proceed to question **6**	☐ No Proceed to question **5**
5. **Please state why the patient cannot take multiple capsules (70 mg or 140 mg capsules) to achieve the patient's daily dose.**	_____ Proceed to question **6**	
6. **Is Imbruvica being prescribed by or in consultation with a hematologist/oncologist?**	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved

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7. Is the patient GREATER THAN or EQUAL to 18 years of age?	☐ Yes Proceed to question **10**	☐ No Proceed to question **8**
8. Is the patient greater than or equal to 1 year(s) of age?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. Does the patient have a diagnosis of chronic graft-versus-host disease?	☐ Yes Proceed to question **16**	☐ No Proceed to question **14**
10. For which indication is Imbruvica being prescribed?	☐ Pretreatment to limit the number of cycles of RhyperCVAD/rituximab maintenance therapy for Mantle Cell Lymphoma – Proceed to question **16** ☐ Second line (or subsequent therapy) for Mantle Cell Lymphoma – Proceed to question **16** ☐ Second line (or subsequent therapy) for Marginal Zone Lymphoma – Proceed to question **16** ☐ Second line (or subsequent therapy) for non-germinal center B cell-like Diffuse Large B cell Lymphoma – Proceed to question **11** ☐ Front line or relapsed refractory therapy for chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) – Proceed to question **12** ☐ Waldenstroms macroglobulinemia – Proceed to question **16** ☐ Chronic graft vs host disease - Proceed to question **16** ☐ Other indication – Proceed to question **14**	
11. Is the patient unable to receive chemotherapy?	☐ Yes Proceed to question **16**	☐ No **STOP** Coverage not approved
12. Does the patient have the del(17p)/TP53 mutation?	☐ Yes Proceed to question **16**	☐ No Proceed to question **13**
13. Does the patient fit into any of the following categories? o Younger than 65 years of age o 65 years of age or older with significant comorbidities o Frail patient with significant comorbidities (not able to tolerate Purine analogs)	☐ Yes Proceed to question **16**	☐ No **STOP** Coverage not approved
14. Please provide the diagnosis.	_____ Proceed to question **15**	

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15. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **16**	☐ No **STOP** Coverage not approved
16. Will the patient be monitored for bleeding, infection, hypertension, cardiac arrhythmias, cytopenias, and Tumor Lysis Syndrome?	☐ Yes Proceed to question **17**	☐ No **STOP** Coverage not approved
17. Is the patient of reproductive age?	☐ Yes Proceed to question **18**	☐ No **Sign and date below**
18. What is the patient's gender?	☐ Male Proceed to question **25**	☐ Female Proceed to question **19**
19. Does the patient agree to use effective contraception during treatment and for at least 30 days after discontinuation?	☐ Yes Proceed to question **20**	☐ No **STOP** **Coverage not approved**
20. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **21**
21. Has it been confirmed that the patient is not pregnant by negative hCG (human chorionic gonadotropin)?	☐ Yes Proceed to question **22**	☐ No **STOP** **Coverage not approved**
22. Is the patient planning to become pregnant?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **23**
23. Is the patient breastfeeding?	☐ Yes Proceed to question **24**	☐ No Proceed to question **25**
24. Has the patient been advised that the potential harm to the infant is unknown?	☐ Yes Proceed to question **25**	☐ No **STOP** Coverage not approved
25. Will the patients of reproductive potential use effective contraception during treatment and for at least 30 days after discontinuation?	☐ 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 _____

[05 April 2023]

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