Prior Authorization Request Form for
venetoclax **(Venclexta)**

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

USFHP Pharmacy Prior Authorization Form

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

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 the requested medication being prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. For which indication is the requested medication being prescribed?	☐ **Frontline therapy for chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) without del(17p)/TP53 mutation** - Proceed to question **4** ☐ **Relapsed/refractory therapy for CLL/SLL without del(17p)/TP53 mutation** - Proceed to question **5** ☐ **Frontline or relapsed/refractory therapy for CLL/SLL with del(17p)/TP53 mutation** - Proceed to question **10** ☐ **Patient has newly diagnosed acute myeloid leukemia (AML) and is a candidate for intensive remission induction therapy** - Proceed to question **6** ☐ **Patient has newly diagnosed AML and is not a candidate for intensive remission induction therapy** - Proceed to question **7** ☐ **Patient has completed lower-intensity induction therapy for AML with a response** - Proceed to question **7** ☐ **Patient has relapsed refractory AML** - Proceed to question **10** ☐ **Other** - Proceed to question **8**	

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4. Will the requested medication be used in combination with obinutuzumab (Gazyva) infusion?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. 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 **10**	☐ No **STOP** **Coverage not approved**
6. Does the patient have unfavorable-risk cytogenetics (exclusive of AML with myelodysplasia-related changes)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the patient greater than or equal to 60 years of age?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
8. Please provide the diagnosis.	_____ Proceed to question **9**	
9. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Will the requested medication be titrated to therapeutic dose in consideration of tumor lysis syndrome (TLS)?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the requested medication be concomitantly used at initiation or during ramp-up with a strong CYP3A inhibitor?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Will the patient be provided prophylaxis and monitored for tumor lysis syndrome (TLS) (based on tumor burden-defined risk)?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Will the patient be monitored for neutropenia?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**

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14. Will the patient be monitored for signs and symptoms of infection?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Will the patient be administered live attenuated vaccines prior to, during, or after treatment with Venclexta until B-cell recovery occurs?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **16**
16. What is the patient's age/gender?	☐ **Male** - Proceed to question **20** ☐ **Female of reproductive potential** - Proceed to question **17** ☐ **Female not of reproductive potential - Sign and date below**	
17. Does the patient agree to use effective contraception during treatment and for at least 30 days after discontinuation?	☐ Yes Proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Is the patient pregnant or planning to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **19**
19. Will the patient breastfeed during treatment?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
20. Are patients informed that Venclexta may cause male infertility?	☐ 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

[13 May 2020]

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