Prior Authorization Request Form for ibrutinib (Imbruvica)

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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. **DOD will allow the clinical Prior Authorization to provide information for the capsules or the tablets. Currently, the capsules are the preferred agent, so if the provider is willing to write for the capsules, then a new prescription will need to be written - but the Prior Authorization will not need to be filled out more than once.**	Proceed to question **2**	
2. **Is Imbruvica being prescribed by or in consultation with a hematologist/oncologist?**	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. **Is the patient GREATER THAN or EQUAL to 18 years of age?**	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. **Is Imbruvica being used as pretreatment to limit the number of cycles of RhyperCVAD/rituximab maintenance therapy for Mantle Cell Lymphoma?**	☐ Yes Proceed to question **14**	☐ No Proceed to question **5**

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5. For which indication is Imbruvica being prescribed?	☐ Second line (or subsequent therapy) for Mantle Cell Lymphoma – Proceed to question **11** ☐ Second line (or subsequent therapy) for Marginal Zone Lymphoma – Proceed to question **11** ☐ Second line (or subsequent therapy) for non-germinal center B cell-like Diffuse Large B cell Lymphoma – Proceed to question **6** ☐ Front line or relapsed refractory therapy for chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) – Proceed to question **7** ☐ Waldenstroms macroglobulinemia – Proceed to question **11** ☐ Chronic graft vs host disease - Proceed to question **11** ☐ Other indication – Proceed to question **9**	
6. Is the patient unable to receive chemotherapy?	☐ Yes Proceed to question **11**	☐ No **STOP** Coverage not approved
7. Does the patient have the del(17p)/TP53 mutation?	☐ Yes Proceed to question **11**	☐ No Proceed to question **8**
8. 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 **11**	☐ No **STOP** Coverage not approved
9. Please provide the diagnosis.	_____ Proceed to question **10**	
10. 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
11. Will the patient be monitored for bleeding, infection, hypertension, cardiac arrhythmias, cytopenias, and Tumor Lysis Syndrome?	☐ Yes Proceed to question **12**	☐ No **STOP** Coverage not approved
12. Is the patient of reproductive age?	☐ Yes Proceed to question **13**	☐ No Proceed to question **14**
13. Will the patients (males and females) of reproductive potential use effective contraception during treatment and for at least 30 days after discontinuation?	☐ Yes Proceed to question **14**	☐ No **STOP** Coverage not approved

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14. What is the patient's gender?	☐ Male Proceed to question **18**	☐ Female Proceed to question **15**
15. Is the patient pregnant or planning to become pregnant?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **16**
16. Is the patient breastfeeding?	☐ Yes Proceed to question **17**	☐ No Proceed to question **18**
17. Has the patient been advised that the potential harm to the infant is unknown?	☐ Yes Proceed to question **18**	☐ No **STOP** Coverage not approved
18. Imbruvica capsules are the DoD's preferred formulation. Is the prescription for Imbruvica capsules OR will the prescription be changed to the capsule formulation?	☐ Yes **Sign and date below**	☐ No Proceed to question **19**
19. Please state why the patient cannot take multiple 70 mg (or 140 mg capsules) to achieve the patient's daily dose.	_____ **Sign and date below**	

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

_____ _____

Prescriber Signature Date

[08 April 2020]

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