PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Imbruvica

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Please provide ICD code(s) for diagnosis.

Q2. For what diagnosis is the drug being prescribed (pick one)?

- ☐ Mantle Cell Lymphoma (MCL)
- ☐ Chronic Lymphocytic Leukemia (CLL)
- ☐ Small lymphocytic lymphoma (SLL)
- ☐ Waldenstrom's Macroglobulinemia (WM)
- ☐ Marginal Zone Lymphoma (MZL)
- ☐ Chronic Graft Versus Host Disease
- ☐ Other

Q3. If you selected "other" in question 2, please provide documentation that use is consistent with a category 1 or higher recommendation per NCCN compendia or guidelines.

Q4. Is prescribing physician a Hematology or Oncology specialist?

☐ Yes ☐ No

Q5. Is the patient an adult (i.e. 18 years or older)?

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Imbruvica

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

☐ Yes ☐ No

Q6. If the diagnosis is MCL, has the patient received at least one prior therapy?

☐ Yes ☐ No

Q7. If the diagnosis is CLL or SLL, does the patient have 17p deletion?

☐ Yes ☐ No

Q8. If the diagnosis is MZL, does the patient require systemic therapy and received at least one prior anit-CD20-based therapy?

☐ Yes ☐ No

Q9. If the diagnosis is cGVHD, has the patient failed one or more lines of systemic therapy?

☐ Yes ☐ No

Q10. Additional Comments

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Imbruvica

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

	Prescriber Name:
Patient Name:	**Supervising Physician:**

hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document