PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D Imbruvica (ibrutinib)

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

Scott & White Health Plan PA Dept. 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. For what diagnosis is the drug being prescribed (pick one)?

☐ Mantle Cell Lymphoma (MCL)
☐ Chronic Lymphocytic Leukemia (CLL)
☐ Waldenstrom's Macroglobulinemia (WM)
☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Is prescribing physician an oncology specialist?

☐ Yes ☐ No

Q4. If the diagnosis is MCL or CLL, has the patient received at least one prior therapy?

☐ Yes ☐ No

Q5. If the diagnosis is CLL, does the patient have 17p deletion?

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

☐ Yes ☐ No	
Q6. 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