SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Imbruvica® (Ibrutinib) Prior Authorization Form

***Member Name:*_____ *Date of Birth:*_____ *Member ID#:*_____**

Drug Information

Pharmacy billing (NDC:_____) *Start Date (or date of next dose):*_____

***Dose:*_____ *Regimen:*_____**

Billing Provider Information

***Provider NPI:*_____ *Provider Name:*_____**

***Provider Phone:*_____ *Provider Fax:*_____**

Prescriber Information

***Prescriber NPI:*_____ *Prescriber Name:*_____**

***Prescriber Phone:*_____ *Prescriber Fax:*_____ *Specialty:*_____**

Criteria

Page 1 of 2—Please complete and return <u>all</u> pages. *Failure to complete all pages will result in processing delays.*

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Will ibrutinib be used as a single-agent? Yes____ No____
2. Will ibrutinib be used for first-line therapy? Yes____ No____
3. Will ibrutinib be used for second-line or subsequent therapy? Yes____ No____
4. Please indicate the diagnosis and information:

- ☐ **Follicular Lymphoma (FL)**
  - A. Is the member's diagnosis Grade 1 or 2 follicular lymphoma? Yes____ No____
  - B. Will ibrutinib be used for subsequent therapy (third-line or greater) for histologic transformation to non-germinal center diffuse large B-cell lymphoma? Yes____ No____
- ☐ **Gastric or Nongastric Mucosa-Associated Lymphoid Tissue (MALT) Lymphoma, Nodal or Splenic Marginal Zone Lymphoma (MZL)**
  - A. Will ibrutinib be used for refractory or progressive disease? Yes____ No____
- ☐ **Chronic Graft-Versus-Host Disease (cGVHD)**
  - A. Has the member had failure of one or more lines of therapy? Yes____ No____
- ☐ **Histologic Transformation of Marginal Zone Lymphoma (MZL) to Diffuse Large B-Cell Lymphoma**
  - A. Will ibrutinib be used as third-line or greater therapy? Yes____ No____
- ☐ **Mantle Cell Lymphoma (MCL)**
  - A. Will ibrutinib be used in combination with rituximab or lenalidomide/rituximab? Yes___ No___
- ☐ **Diffuse Large B-Cell Lymphoma or Acquired Immunodeficiency Syndrome (AIDS)-Related B-Cell Lymphoma**
  - A. Is the member's diagnosis non-germinal center diffuse large B-cell lymphoma? Yes___ No___
  - B. Is member a candidate for high-dose therapy? Yes____ No____
- ☐ **Post-Transplant Lymphoproliferative Disorders**
  - A. Is the member's diagnosis non-germinal center B-cell type? Yes____ No____
  - B. Please indicate member's disease status:
    - ☐ Partial therapy response
    - ☐ Persistent disease
    - ☐ Progressive disease
- ☐ **Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)**
  - A. Will ibrutinib be used in combination with bendamustine and rituximab? Yes____ No____

Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.
Please do not send in chart notes. Specific information will be requested if necessary.

<u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u>	<u>CONFIDENTIALITY NOTICE</u>
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

4. Please indicate the diagnosis and information, continued:
   - ☐ **Hairy Cell Leukemia**
     A. Does member have disease progression? Yes____ No____
   - ☐ **Waldenström's Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma**
     A. Will ibrutinib be used in combination with rituximab (Rituxan®)? Yes____ No____
   - ☐ **If diagnosis is not listed above, please indicate diagnosis:**_____

Additional Information:_____
_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on ibrutinib? Yes____ No____
3. Has the member experienced any adverse drug reactions related to ibrutinib therapy? Yes____ No____
   *If yes, please specify adverse reactions:*_____

Additional Information:_____
_____

Please complete and return all pages. Failure to complete all pages will result in processing delays.
Please do not send in chart notes. Specific information will be requested if necessary.

Prescriber Signature:_____ Date:_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.
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