PRO ACT PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Imbruvica® Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic lymphocytic leukemia (CLL)
❑ Chronic graft versus host disease (cGVHD)
❑ Mantle cell lymphoma (MCL)
❑ Marginal zone lymphoma (MZL)
❑ Small lymphocytic lymphoma (SLL)
❑ W aldenström's macroglobulinemia/lymphoplasmacytic lymphoma
❑ Other diagnosis:_____ICD-10 Code(s): _____

Prescriber's Specialty:

Select if Imbruvica is prescribed by or in consultation with the following specialists:
❑ Hematologist ❑ Oncologist ❑ Physician experienced in the management of transplant patients

For chronic graft versus host disease, answer the following:

Has the patient had trial and failure of at least one or more lines of systemic therapy (e.g., corticosteroids, mycophenolate)? ❑ **Yes** ❑ **No**

For mantle cell lymphoma (MCL), answer the following:

Has the patient received at least one prior therapy for MCL (e.g., Rituxan [rituximab])? ❑ **Yes** ❑ **No**

For marginal zone lymphoma (MZL), answer the following:

Has the patient received at least one prior anti-CD20-based therapy for MZL [e.g., Rituxan (rituximab), Zevalin (ibritumomab), Gazyva (obinutuzumab, etc.)]? ❑ **Yes** ❑ **No**

Reauthorization:
If this is a reauthorization request, answer the following question:

Does the patient show evidence of progressive disease while on Imbruvica therapy? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	