

Imbruvica® (ibrutinib) Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code: _____) **Pharmacy billing** (NDC: _____)

Dose: _____ **Regimen:** _____ **Start Date (or date of next dose):** _____

Billing Provider Information

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

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

Prescriber Information

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

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

Criteria

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:
 - Chronic Graft-Versus-Host Disease (cGVHD)**
 - A. Has the member had failure of 1 or more lines of therapy? Yes No
 - B. If member is younger than 12 years of age, please provide their current body surface area (BSA): _____
 - C. If member is younger than 12 years of age, and this request is for the 70mg capsule formulation, please provide a patient-specific clinically significant reason why the member cannot use the 70mg/ml oral suspension formulation: _____
 - B-Cell Lymphomas**
 - A. Does member's diagnosis include diffuse large B-cell lymphomas, human immunodeficiency virus (HIV)-related B-cell lymphomas, post-transplant lymphoproliferative disorders, or high grade B-cell lymphoma? Yes No
 - Mantle Cell Lymphoma (MCL)**
 - A. Will ibrutinib be used in combination with rituximab prior to induction therapy? Yes No
 - B. Will ibrutinib be used as a component of aggressive induction therapy? Yes No
 - C. Will ibrutinib be used as maintenance therapy following aggressive induction therapy or hematopoietic stem cell transplant (HSCT)? Yes No
 - Diffuse Large B-Cell Lymphoma (DLBCL) 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 CAR T-cell therapy or intends to proceed to transplant? Yes No

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<p>Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.</p>	<p style="text-align: center;"><u>CONFIDENTIALITY NOTICE</u></p> <p><i>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.</i></p>
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Criteria

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4. Please indicate the diagnosis and information, continued:

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

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 rituximab, obinutuzumab, or venetoclax? Yes No

Hairy Cell Leukemia

A. Will ibrutinib be used as third-line or subsequent therapy for refractory or progressive disease?
Yes No

Waldenström's Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma

A. Will ibrutinib be used in combination with rituximab (Rituxan®)? Yes No

Primary Central Nervous System (CNS) Lymphoma

A. Is member not a candidate for, or intolerant to high-dose methotrexate? Yes No

B. Will ibrutinib be used for refractory or progressive disease? 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: _____

(Page 2 of 2)

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. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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