OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Venclexta® (venetoclax) Prior Authorization Form

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

Drug Information

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

Dose:_____ Regimen:_____

Pharmacy Information

Pharmacy NPI:_____ Pharmacy Name:_____

Pharmacy Phone:_____ Pharmacy Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

For Initial Authorization:

1. Will venetoclax be used as a single-agent? Yes☐ No☐
2. Will venetoclax be used as first-line therapy? Yes☐ No☐
3. Will venetoclax be used as second-line or subsequent therapy? Yes☐ No☐
4. Will venetoclax be used for relapsed or refractory disease? Yes☐ No☐
5. Please indicate the diagnosis and information:
   - ☐ **Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lympoma (SLL)**
     - A. Will venetoclax be used in combination with obinutuzumab? Yes☐ No☐
     - B. Will venetoclax be used in combination with ibrutinib? Yes☐ No☐
     - C. Will venetoclax be used in combination with rituximab? Yes☐ No☐
   - ☐ **Acute Myeloid Leukemia (AML)**
     - A. Will venetoclax be used in combination with azacitidine, decitabine, or low-dose cytarabine? Yes☐ No☐
     - B. Is member younger than 75 years of age and unable to tolerate intensive induction chemotherapy? Yes☐ No☐
   - ☐ **Mantle Cell Lymphoma (MCL)**
   - ☐ **Other:** _____

Additional Information: _____

_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on venetoclax? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to venetoclax therapy? Yes☐ No☐

If yes, please specify adverse reactions: _____

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.

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.	