

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

***Page 1 of 2—Please complete and return all 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, rituximab, or obinutuzumab? Yes ___ No ___

Page 1 of 2

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.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

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

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

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

Criteria

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: _____

Page 2 of 2

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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