

State of Oklahoma **SoonerCare**

Venclexta® (Venetoclax) Prior Authorization Form

Member Name:	Date of Birth:	
	Drug Information	on
Pharmacy billing (NDC:) Start Date (or date of next dose):		te (or date of next dose):
	Billing Provider Infor	mation
Providor NPI:		
	Provider Name: Provider Fax:	
	Prescriber Informa	
Prescriber NPI		
		Specialty:
	Criteria	
For Initial Authorization:	Ontona	
A. Will venetoclax be i. If "Yes", please Form (Pharm-1 B. Will venetoclax be Acute Myeloid Leuke A. Will venetoclax be Yes No B. Is member younge Yes No If diagnosis is not lis	lapsed or refractory disease? Ye and information: na (MCL) c Leukemia (CLL)/Small Lymph used in combination with obinutu c completely fill out and submit th 100) that is available on the OHC used in combination with rituxima mia (AML) used in combination with azacitic r than 75 years of age and unable ted above, please indicate diag	nocytic Lymphoma (SLL) uzumab? Yes No ne Gazyva® (obinutuzumab) Prior Authorization cA website: www.okhca.org.
For Continued Authorization: 1. Date of last dose: 2. Does member have any evide 3. Has the member experienced If yes, please specify adventage of the specific process.	erse reactions:	e on venetoclax? Yes No ted to venetoclax therapy? Yes No
Prescriber Signature:		
I certify that the indicated treatment is	medically necessary and all informa	tion is true and correct to the best of my knowledge. ssary. Failure to complete this form in full will result in

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

processing delays.

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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