Please complete ALL information below and fax your request to 1-888-671-5285

Imbruvica® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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 **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

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

Prescriber's Specialty:
Select if Imbruvica is prescribed by or in consultation with one of 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**

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

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

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