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

Venclexta® 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:

- ❑ Acute myeloid leukemia (AML)
- ❑ Chronic lymphocytic leukemia (CLL)
- ❑ Small lymphocytic lymphoma (SLL)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Is Venclexta prescribed by or in consultation with a hematologist/oncologist? ❑ **Yes** ❑ **No**

Acute Myeloid Leukemia (AML):

Does the patient have newly diagnosed disease? ❑ **Yes** ❑ **No**

Will Venclexta be used in combination with azacitidine, or decitabine, or low-dose cytarabine? ❑ **Yes** ❑ **No**

Does the patient have comorbidities that preclude the use of intensive induction chemotherapy? ❑ **Yes** ❑ **No**

Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL):

Has the patient received at least one prior therapy (e.g., Cytoxan [cyclophosphamide], Fludara [fludarabine], Rituxan [rituximab])? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient show evidence of progressive disease while on Venclexta 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?

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