



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:
<input type="checkbox"/> Check if generic substitution is acceptable		Directions for Use:
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Acute myeloid leukemia (AML)	
<input type="checkbox"/> Chronic lymphocytic leukemia (CLL)	
<input type="checkbox"/> Small lymphocytic lymphoma (SLL)	
<input type="checkbox"/> Other diagnosis: _____	ICD-10 Code(s): _____
Prescriber's Specialty:	
Is Venclexta prescribed by or in consultation with a hematologist/oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Acute Myeloid Leukemia (AML):	
Does the patient have newly diagnosed disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will Venclexta be used in combination with azacitidine, or decitabine, or low-dose cytarabine? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient have comorbidities that preclude the use of intensive induction chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> 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])? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reauthorization:	
Does the patient show evidence of progressive disease while on Venclexta therapy? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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