OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare

Imbruvica® (ibrutinib) Prior Authorization Form

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

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:

☐ **Chronic Graft-Versus-Host Disease (cGVHD)**

A. Has the member had failure of 1 or more lines of therapy? Yes☐ No☐
B. If member is younger than 12 years of age, please provide their current body surface area (BSA): _____
C. If member is younger than 12 years of age, and this request is for the 70mg capsule formulation, please provide a patient-specific clinically significant reason why the member cannot use the 70mg/ml oral suspension formulation: _____

_____

☐ **B-Cell Lymphomas**

A. Does member's diagnosis include diffuse large B-cell lymphomas, human immunodeficiency virus (HIV)-related B-cell lymphomas, post-transplant lymphoproliferative disorders, or high grade B-cell lymphoma? Yes☐ No☐
B. Is member not a candidate for CAR T-cell therapy or has no intention to proceed to transplant? Yes☐ No☐

☐ **Mantle Cell Lymphoma (MCL)**

A. Will ibrutinib be used in combination with rituximab prior to induction therapy? Yes☐ No☐
B. Will ibrutinib be used as a component of aggressive induction therapy? Yes☐ No☐
C. Will ibrutinib be used as maintenance therapy following aggressive induction therapy or hematopoietic stem cell transplant (HSCT)? Yes☐ No☐

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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Page 2 of 2—Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.

4. Please indicate the diagnosis and information, continued:

☐ **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 rituximab, obinutuzumab, or venetoclax? Yes☐ No☐

☐ **Hairy Cell Leukemia**
- A. Will ibrutinib be used as third-line or subsequent therapy for refractory or progressive disease? Yes☐ No☐

☐ **Primary Central Nervous System (CNS) Lymphoma**
- A. Is member not a candidate for, or intolerant to high-dose methotrexate? Yes☐ No☐
- B. Will ibrutinib be used for refractory or progressive disease? Yes☐ No☐

☐ **Waldenström's Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma**
- A. Will ibrutinib be used in combination with rituximab (Rituxan®)? Yes☐ No☐

☐ **Other:** _____

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: _____

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. *Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

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