OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Calquence® (acalabrutinib) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Pharmacy Billing (NDC: _____***) Start Date (or date of next dose):*** _____

Dose: _____ ***Regimen:*** _____

Pharmacy Information

Pharmacy NPI: _____ ***Pharmacy Name:*** _____

Pharmacy Phone: _____ ***Pharmacy Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:
   - ☐ **Mantle Cell Lymphoma (MCL)**
     - A. Will acalabrutinib be used after at least 1 prior line of therapy? Yes☐ No☐
       - i. If yes, will acalabrutinib be used as a single agent? Yes☐ No☐
     - B. Is MCL previously untreated? Yes☐ No☐
       - i. If yes, will acalabrutinib be used in combination with bendamustine and rituximab? Yes☐ No☐
       - ii. Is member ineligible for autologous hematopoietic stem cell transplantation (HSCT) Yes☐ No☐
   - ☐ **Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)**
     - A. Will acalabrutinib be used as a single agent? Yes☐ No☐
     - B. Will acalabrutinib be used in combination with obinutuzumab and/or venetoclax? Yes☐ No☐
   - ☐ **Other** _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on acalabrutinib? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to acalabrutinib 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.

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.*