

# Boruzu<sup>®</sup> (bortezomib) 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:

1. Please provide all of the following:

A. Diagnosis: \_\_\_\_\_

B. A patient-specific, clinically significant reason why the member cannot use generic Velcade<sup>®</sup> (bortezomib), which is available without a prior authorization:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional Information: \_\_\_\_\_  
\_\_\_\_\_

### For Continued Authorization:

1. Date of last dose: \_\_\_\_\_

2. Does patient have any evidence of progressive disease while on Boruzu<sup>®</sup> therapy? Yes \_\_\_ No \_\_\_

3. Has the member experienced any adverse drug reactions related to Boruzu<sup>®</sup> therapy? Yes \_\_\_ No \_\_\_

If yes, please specify adverse reactions: \_\_\_\_\_

Additional Information: \_\_\_\_\_  
\_\_\_\_\_

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. Failure to complete this form in full will result in processing delays.**

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

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

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