# Brukinsa (zanubrutinib) Prior Authorization Request Form

Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

MEMBER INFORMATION	
LAST NAME:	FIRST NAME:
PHONE NUMBER:	DATE OF BIRTH:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
PATIENT INSURANCE ID NUMBER:	
MALE FEMALE HEIGHT (IN/CM): WEIGI	HT (LB/KG): ALLERGIES:

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: <u>PRIMETHERAPEUTICS.COM/NOPP</u>

#### 

PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION					
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:		
NEW THERAPY		IF RENEWAL: DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):					

Continued on next page.



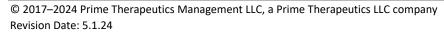
# Brukinsa (zanubrutinib)

## **Prior Authorization Request Form**

Caterpillar Prescription Drug Benefit

Phone: 877-228-7909 Fax: 800-424-7640

14. HAS THE PATIENT TRIED ANY OFHER MEDICATIONS FOR THIS CONDITION?       VES (if ves, complete below)       NO         MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):       DURATION OF THERAPY (SPECIFY DATES):       RESPONSE/REASON FOR FAILURE/ALLERGY:         2. LIST DIAGNOSES:       DATES):       ICD-10:         Mantle Cell Lymphoma (MCL)       Chronic Lymphoma(MCL)       Chronic Lymphoma(MCL)         Other diagnosis:       ICD-10 Code(s):       Stepensory CLI/SLL         Relapsed or Refractory CLL/SLL       ICD-10 Code(s):       Stepensory CLI/SCL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.         Clinical Information:       Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? □ Yes □ No         For diagnosis of Mantle Cell Lymphoma(MCL), please answer the following:       Does the patient have measurable disease as confirmed by a computed tomography/magnetic resonance imaging laboratory report? □ Yes □ No         Does the patient's disease have histologic evidence of MCL morphology? □ Yes □ No       Please submit documentation         Is the patient failed one previous therapy for MCL? □ Yes □ No       Please submit documentation         Has the patient failed one previous therapy for MCL? □ Yes □ No       Please submit documentation         Has the patient failed one previous therapy for MCL? □ Yes □ No       Please submit documentation         Has the patient failed one previous therap				
DRUG NAME AND DOSAGE):       DATES):       FAILURE/ALLERGY:         2. LIST DIAGNOSES:       ICD-10:         Mantie Cell Lymphoma (MCL)       Waldenstrom's Macroglubinemia(WM)         Marginal Zone Lymphoma(MZL)       Chronic Lymphoma(MZL)         Chronic Lymphoma(MZL)       ICD-10 Code(s):         Relapsed or Refractory CLL/SLL       ICD-10 Code(s):         S. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.         Clinical Information:       Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial?         To Be patient have measurable disease as confirmed by a computed tomography/magnetic resonance imaging laboratory report?       Yes □ No         Picos the patient's disease have histologic evidence of MCL morphology?       Yes □ No         Does the patient's disease have histologic evidence of MCL morphology?       Yes □ No         Is the patient's disease have histologic evidence of MCL morphology?       Yes □ No         Picase submit documentation       Has the patient previous therapy for MCL?       Yes □ No         Has the patient failed one previous therapy for MCL?       Yes □ No       Please submit documentation         Has the patient previously had treatment with another BTK inhibitor (such as Calquence * / acalabrutinib or Imbruvica * / ibrutinib)?       Yes □ No         Is the patient Eastern Cooperative O				
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<ul> <li>□ Chronic Lymphacytic Leukemia(CLL / SLL)</li> <li>□ Other diagnosis:</li></ul>				
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□ Yes □ No Please submit documentation For diagnosis of Waldenstrom's Macroglubinemia, please answer the following:				
For diagnosis of Waldenstrom's Macroglubinemia, please answer the following:				
Has patient had at least one prior therapy?  Yes  No Please submit documentation.				
Has patient had at least one prior therapy?   Yes  No Please submit documentation.				
Has patient had prior treatment with a BTK inhibitor such as Imbruvica(ibrutinib) or Calquence(acalabrutinib)?				
Yes 🗆 No Please submit documentation.				
For Marginal Zone Lymphoma, please answer the following:				
For Marginal Zone Lymphoma, please answer the following:				



## Brukinsa (zanubrutinib) Prior Authorization Request Form Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

Has patient had at least one prior therapy with an anti-CD20-based regimen such as rituximab, ibritumomab(Zevalin), obinutuzumab(Gazyva), Tositumomab (Bexxar) or ofatumumab(Arzerra ? 
Yes 
No Please submit documentation.

Has patient had prior treatment with a BTK inhibitor such as Imbruvica(ibrutinib) or Calquence(acalabrutinib)? Yes  $\Box$  No *Please submit documentation.* 

For diagnosis of Chronic Lymphacytic Leukemia(CLL / SLL), please answer the following: Does patient have a diagnosis of CD20 positive CLL/SLL? 
Ves 
No Please submit documentation.

Has patient been previously treated for their CLL/ SLL? 
□ Yes □ No Please submit documentation.

Has patient been previously treated with at least one systemic therapy? 
□ Yes □ No Please submit documentation.

If patient had been previously treated, did patient have at least 2 cycles of treatment? 

Yes 
No Please submit documentation.

Is patient unable to be treated with fludarabine, cyclophosphamide, and rituximab(FCR)? 
Ves ON Please submit documentation.

Does patient have an Eastern Cooperative Oncology Group(ECOG) performance score of 0,1, or 2? 
Ves Please submit documentation.

Has patient been previously treated with a BTK inhibitor such as ibrutinib(Imbruvica), acalabrutinib(Calquence), zanubrutinib(Brukinsa), tirabrutinib(Velexbru) or orleabrutinib(Hibruka)? 
Solve Yes 
No Please submit documentation.

For diagnosis of Follicular Lymphoma(FL), please answer the following: Has patient been treated with 2 or more prior systemic treatments for follicular lymphoma? 
• Yes • No Please submit documentation.

Was patient previously receiving an anti-CD20 antibody and an appropriate alkylator-based combination therapy? □ Yes □ No Please submit documentation.

Does patient have disease progression after completion of the most recent therapy or refractory disease? □ Yes □ No *Please submit documentation.* 

Does patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0,1 or 2? 
Ves 
No

Has patient had prior treatment with a Bruton's tyrosine kinase (BTK) inhibitor such as tirabrutinib(Velexbru), orleabrutinib(Hibruka), Imbruvica(ibrutinib), Calquence(acalabrutinib) or Brukinsa(zanubrutinib)? 
Solve Submit documentation.

Will patient use Brukinsa(zanubrutinib) in combination with obinutuzumab(Gazyva)? 
Yes ON Please submit documentation.

<sup>@</sup> 2017–2024 Prime Therapeutics Management LLC, a Prime Therapeutics LLC company Revision Date: 5.1.24

## Brukinsa (zanubrutinib) Prior Authorization Request Form Caterpillar Prescription Drug Benefit

Phone: 877-228-7909 Fax: 800-424-7640

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?		
<b>Please note:</b> Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.		
<b>ATTESTATION:</b> I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.		
Prescriber Signature or Electronic I.D. Verification: Date: Date:		
<b>CONFIDENTIALITY NOTICE:</b> The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.		

### FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program Attn:CP-4201 P.O.Box 64811 St. Paul, MN 55164-0811 Phone: 877-228-7909

