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.

☐ **URGENT**

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):** _____ **WEIGHT (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: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

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** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Mantle Cell Lymphoma (MCL) ☐ Waldenstrom's Macroglubinemia(WM) ☐ Marginal Zone Lymphoma(MZL) ☐ Chronic Lymphacytic Leukemia(CLL / SLL) ☐ Relapsed or Refractory CLL/SLL ☐ Other diagnosis: _____ICD-10 Code(s):	

3. 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? ☐ Yes ☐ No

<u>For diagnosis of Mantle Cell Lymphoma(MCL),</u> please answer the following:

Does the patient have measurable disease as confirmed by a computed tomography/magnetic resonance imaging laboratory report? ☐ Yes ☐ No *Please submit documentation*

Does the patient's disease have histologic evidence of MCL morphology? ☐ Yes ☐ No *Please submit documentation*

Is the patient's tumor positive for a t(11; 14) translocation AND/OR overexpression of cyclin D1?
☐ Yes ☐ No *Please submit documentation*

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 Oncology Group (ECOG) performance status of 0, 1 or 2 (is ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours?
☐ Yes ☐ No *Please submit documentation*

<u>For diagnosis of Waldenstrom's Macroglubinemia</u>, please answer the following:

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.*

<u>For Marginal Zone Lymphoma</u>, please answer the following:

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** □ **No** ***Please submit documentation.***

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

Does patient have an Eastern Cooperative Oncology Group(ECOG) performance score of 0,1, or 2? □ **Yes** □ **No** ***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)? □ **Yes** □ **No** ***Please submit documentation.***

<u>For diagnosis of Follicular Lymphoma(FL), please answer the following</u>:
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? □ **Yes** □ **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)? □ **Yes** □ **No** ***Please submit documentation.***

Will patient use Brukinsa(zanubrutinib) in combination with obinutuzumab(Gazyva)? □ **Yes** □ **No** ***Please submit documentation.***

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: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: 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: _____

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