

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

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

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:
REQUESTER (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY <input type="checkbox"/> RENEWAL		IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?		
<input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Mantle cell lymphoma <input type="checkbox"/> Chronic lymphocytic leukemia(CLL) <input type="checkbox"/> Small lymphocytic lymphoma(SLL) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s):		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
Is patient going to be using drug in combination with a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<u>For diagnosis of mantle cell lymphoma:</u> Has the patient ever been treated for mantle cell lymphoma? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had at least one prior therapy for mantle cell lymphoma?* <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i> Has the patient been previously treated with another Bruton tyrosine kinase (BTK) inhibitor such as Imbruvica (ibrutinib)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient ineligible for an autologous hematopoietic stem cell transplant(HSCT)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>No*Please submit documentation.</i> Will patient use Calquence(acalabrutinib) in combination with rituximab and bendamustine? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>No *Please submit documentation.</i> <u>For diagnosis of chronic lymphocytic leukemia(CLL) or small lymphocytic lymphoma(SLL):</u> Has patient received any prior systemic therapies for CLL /SLL? <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have a del(17p) or TP53 mutation, or complex karyotype (defined as defined as the presence of 3 or more chromosomal aberrations in 2 or more metaphases) or an unmutated IGHV gene status ? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i> Will patient be using Calquence in combination with obinutuzumab(Gazyva©)? <input type="checkbox"/> Yes <input type="checkbox"/> No Has patient received at least one prior therapy for CLL/SLL? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i>		

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Will patient be using Calquence as Monotherapy? Yes No

Will patient use in combination with Venclexta(venetoclax) Yes No

Renewal Request:

Is patient continuing to demonstrate a positive clinical response? 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:** _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
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St. Paul, MN 55164-0811
Phone: 877-228-7909