

Venclexta (venetoclax)
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:	

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MEDICATION OR MEDICAL DISPENSING INFORMATION

MEDICATION NAME: _____

DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
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NEW THERAPY RENEWAL IF RENEWAL, DATE THERAPY INITIATED: _____
 DURATION OF THERAPY (SPECIFIC DATES): _____

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:**

<input type="checkbox"/> Chronic lymphocytic leukemia (CLL) <input type="checkbox"/> Small lymphocytic leukemia (SLL) <input type="checkbox"/> Acute myeloid leukemia (AML) <input type="checkbox"/> Myelodysplastic syndrome(MDS) <input type="checkbox"/> Other diagnosis: _____ <div style="text-align: right; margin-top: 5px;">ICD-10 CODE(S): _____</div>	
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3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
Renewal Request:
 Is patient continuing to have a positive clinical response? Yes No *Please submit documentation.*

For the diagnosis of CLL or SLL, please answer the following:

Does the patient have a diagnosis of relapsed/refractory chronic lymphocytic leukemia (CLL) with Del (17p)?* Yes No **Chart documentation of CLL with 17p deletion must be provided.*

Does patient have a del(17p) or 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 ? Yes No **Please submit documentation.*



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Has the patient received at least one prior therapy for the treatment of CLL?* Yes No

**Chart documentation of prior therapy must be submitted for review.*

Will Venclexta(venetoclax) be used as monotherapy? Yes No

Will Venclexta(venetoclax) be used in combination with Calquence(acalabrutinib) with or without Gazyva(obinutuzimab)? Yes No

Will the patient be using rituximab in conjunction with Venclexta(venetoclax) for the treatment of CLL or SLL? Yes No

Has the patient received NO prior treatments for their CLL or SLL? Yes No

Will the patient be using Venclexta in conjunction with Gazyva(obinutuzumab)? Yes No

For the diagnosis of AML and treatment with Venclexta AND decitabine , please answer the following:

Is patient newly diagnosed acute myeloid leukemia(AML)? Yes No *Please submit histology report.*

Is the patient eligible for standard induction chemotherapy? Yes No *Please submit documentation.*

Will the patient use Venclexta in conjunction with decitabine? Yes No

For the diagnosis of AML and treatment with Venclexta(venetoclax) AND azacitidine or low dose cytarabine, please answer the following:

Has the patient received prior treatment for AML? Yes No

Will Venclexta be used in combination with azacitidine? Yes No

Will Venclexta be used in combination with low dose cytarabine? Yes No

Does patient's AML have a favorable risk cytogenetics, per NCCN Guidelines (such as t[8;21], inv[16], t[16:16] or t[15:17])? Yes No *Please submit lab report.*

Does patient have active CNS involvement? Yes No

Does patient have promyelocytic leukemia? Yes No

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Has patient previously received ANY of the following treatments for myelodysplastic syndrome (MDS): decitabine (Dacogen®), azacitidine (Vidaza®), venetoclax (Venclexta®) or chemotherapy? Yes No

Has patient received prior CAR-T therapy? Yes No

For patients age 18-74 years ONLY: Does patient meet at least ONE of the following? Yes No

Please check option(s) AND Please submit chart documents.:

- Unable to carry out any work activities
- Positive cardiac history for congestive heart failure requiring treatment
- Presence of chronic stable angina
- Ejection fraction NO GREATER THAN 50%
- Pulmonary function testing shows DLCO equals NO GREATER THAN 65%
- Pulmonary function testing shows FEV1 equals NO GREATER THAN 65%
- Creatinine clearance equals 30 – 44 mL/min
- Total bilirubin level equals 1.5 – 3 times upper limit of normal
- Patient has another comorbidity rendering him/her ineligible for standard intensive chemotherapy (please explain)

For the diagnosis of MDS AND treatment with Venclexta in combination with azacitidine, please answer the following:

Does the patient have newly diagnosed MDS? Yes No

Has patient been previously treated for their MDS? Yes No

Will Venclexta be used in combination with azacitidine? Yes No

Does patient have an IPSS(International Prognostic Scoring System) risk score that equals at least 1.5?
 Yes No *Please submit documentation.*

Does patient have a Revised (IPSS-R) risk score that equals greater than 3? Yes No
Please submit documentation.

Has patient's MDS evolved from another pre-existing myeloproliferative neoplasm(MPN)? Yes No

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Does the patient have any of the following? Yes No Please check.

chronic myelomonocytic leukemia(CMML)

atypical chronic myeloid leukemia(CML)

juvenile myelomonocytic leukemia(JMML)

any other unclassifiable MDS/MPN

Has the patient received a hematopoietic stem cell transplantation(HSCT)? Yes No

Has patient had a solid organ transplant? Yes No

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
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909