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

Continued on next page

Revision Date: 7/1/2023

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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:**
□ Chronic lymphocytic leukemia (CLL) □ Small lymphocytic leukemia (SLL) □ Acute myeloid leukemia (AML) □ Myelodysplastic syndrome(MDS) □ Other diagnosis: _____ICD-10_____	

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.***

<u>For the diagnosis of CLL or SLL,</u> 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.

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 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

<u>For the diagnosis of AML and treatment with Venclexta AND decitabine</u> , 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

<u>For the diagnosis of AML and treatment with Venclexta(venetoclax) AND azacitidine or low dose cytarabine</u>, please answer the following:
Has the patient received prior treatment for AML? □ Yes □ No

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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

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

Does the patient have any of the following? □ Yes □ No *Please check.*
□ chronic myelomonocytic leukemia(CMML)

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□ **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:** _____

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