State of Oklahoma
SoonerCare
Imbruvica® (Ibrutinib) Prior Authorization Form

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Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

☐ ***Physician billing*** **(HCPCS code:** _____**)** ☐ ***Pharmacy billing*** **(NDC:** _____**)**

Dose: _____ ***Regimen:*** _____ ***Start Date (or date of next dose):*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty*:** _____

Criteria

Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Will ibrutinib be used as a single-agent? Yes ☐ No ☐
2. Will ibrutinib be used for first-line therapy? Yes ☐ No ☐
3. Will ibrutinib be used for second-line or subsequent therapy? Yes ☐ No ☐
4. Please indicate the diagnosis and information:

☐ **Follicular Lymphoma (FL)**
- A. Is the member's diagnosis Grade 1 or 2 follicular lymphoma? Yes ☐ No ☐
- B. Will ibrutinib be used for subsequent therapy (third-line or greater) for histologic transformation to non-germinal center diffuse large B-cell lymphoma? Yes ☐ No ☐

☐ **Gastric or Nongastric Mucosa-Associated Lymphoid Tissue (MALT) Lymphoma, Nodal or Splenic Marginal Zone Lymphoma (MZL)**
- A. Will ibrutinib be used for refractory or progressive disease? Yes ☐ No ☐

☐ **Chronic Graft-Versus-Host Disease (cGVHD)**
- A. Has the member had failure of 1 or more lines of therapy? Yes ☐ No ☐
- B. If member is younger than 12 years of age, please provide their current body surface area (BSA): _____
- C. If member is younger than 12 years of age, and this request is for the 70mg capsule formulation, please provide a patient-specific clinically significant reason why the member cannot use the 70mg/ml oral suspension formulation: _____

☐ **Histologic Transformation of Marginal Zone Lymphoma (MZL) to Diffuse Large B-Cell Lymphoma**
- A. Will ibrutinib be used as third-line or greater therapy? Yes ☐ No ☐

☐ **Mantle Cell Lymphoma (MCL)**
- A. Will ibrutinib be used in combination with rituximab or lenalidomide/rituximab? Yes ☐ No ☐

☐ **Diffuse Large B-Cell Lymphoma or Acquired Immunodeficiency Syndrome (AIDS)-Related B-Cell Lymphoma**
- A. Is the member's diagnosis non-germinal center diffuse large B-cell lymphoma? Yes ☐ No ☐
- B. Is member a candidate for high-dose therapy? Yes ☐ No ☐

Please complete and return all pages. Failure to complete all pages will result in processing delays.
Please do not send in chart notes. Specific information will be requested if necessary.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma**.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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Page 2 of 2—Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.

4. Please indicate the diagnosis and information, continued:
   - ☐ **Post-Transplant Lymphoproliferative Disorders**
     - A. Is the member's diagnosis non-germinal center B-cell type? Yes☐ No☐
     - B. Please indicate member's disease status:
       - ☐ Partial therapy response
       - ☐ Persistent disease
       - ☐ Progressive disease
   - ☐ **Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)**
     - A. Will ibrutinib be used in combination with bendamustine, rituximab, or obinutuzumab? Yes☐ No☐
   - ☐ **Hairy Cell Leukemia**
     - A. Does member have disease progression? Yes☐ No☐
   - ☐ **Waldenström's Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma**
     - A. Will ibrutinib be used in combination with rituximab (Rituxan®)? Yes☐ No☐

If diagnosis is not listed above, please indicate diagnosis: _____
Additional Information: _____
_____

For Continued Authorization:
1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on ibrutinib? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to ibrutinib therapy? Yes☐ No☐
   If yes, please specify adverse reactions: _____

Additional Information: _____
_____

Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.
Please do not send in chart notes. Specific information will be requested if necessary.

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.
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