



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: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://magellanrx.com/member/external/commercial/common/doc/en-us/phi-disclosure-authorization.pdf)

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:
<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 (MCL) <input type="checkbox"/> Waldenstrom's Macroglobulinemia(WM) <input type="checkbox"/> Marginal Zone Lymphoma(MZL) <input type="checkbox"/> Chronic Lymphocytic Leukemia(CLL / SLL) <input type="checkbox"/> Relapsed or Refractory CLL/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.		
Clinical Information: Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>For diagnosis of Mantle Cell Lymphoma(MCL), please answer the following:</u> Does the patient have measurable disease as confirmed by a computed tomography/magnetic resonance imaging laboratory report? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i> Does the patient's disease have histologic evidence of MCL morphology? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i> Is the patient's tumor positive for a t(11; 14) translocation AND/OR overexpression of cyclin D1? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i> Has the patient failed one previous therapy for MCL? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i> Has the patient previously had treatment with another BTK inhibitor (such as Calquence® / acalabrutinib or Imbruvica® / ibrutinib)? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i> <u>For diagnosis of Waldenstrom's Macroglobulinemia, please answer the following:</u> Has patient had at least one prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i> Has patient had prior treatment with a BTK inhibitor such as Imbruvica(ibrutinib) or Calquence(acalabrutinib)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i> <u>For Marginal Zone Lymphoma, please answer the following:</u>		





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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.

For diagnosis of Chronic Lymphocytic Leukemia(CLL / SLL), please answer the following:

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

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: Magellan Rx Management Prior Authorization Program
Attn:CP-4201
P.O.Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909

