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

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.

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

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:**
□ Mantle Cell Lymphoma (MCL) □ Waldenstrom's Macroglubinemia(WM) □ Marginal Zone Lymphoma(MZL) □ 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? □ Yes □ No

For diagnosis of Mantle Cell Lymphoma(MCL), please answer the following:
Does the patient have measurable disease as confirmed by a computed tomography/magnetic resonance imaging laboratory report? □ Yes □ No ***Please submit documentation***

Does the patient's disease have histologic evidence of MCL morphology? □ Yes □ No ***Please submit documentation***

Is the patient's tumor positive for a t(11; 14) translocation AND/OR overexpression of cyclin D1?
□ Yes □ No ***Please submit documentation***

Has the patient failed one previous therapy for MCL? □ Yes □ No ***Please submit documentation***

Has the patient previously had treatment with another BTK inhibitor (such as Calquence ® / acalabrutinib or Imbruvica ® / ibrutinib)? □ Yes □ 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 ?
□ Yes □ No ***Please submit documentation***

For diagnosis of Waldenstrom's Macroglubinemia, please answer the following:

Has patient had at least one prior therapy? □ 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 Marginal Zone Lymphoma, please answer the following:

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Magellan Rx MANAGEMENT

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

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 Imb ruvica(ibrutinib) or Calquence(acalabrutinib)? □ 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: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

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Magellan Rx MANAGEMENT℠