

Calquence (acalabrutinib) 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.

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: <u>https://magellanrx.com/member/external/commercial/common/doc/en-us/phi_disclosure_authorization.pdf</u>

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:	
DURATION OF THERAPY (SPE	RENEWAL CIFIC DATES):	IF RENEWAL: DATE THERAPY INITIATED:		

Continued on next page.





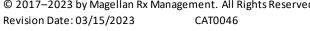


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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHE	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) 🗌 NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
 Mantle cell lymphoma Chronic lymphocytic leukemia(CLL) Small lymphocytic lymphoma(SLL) 				
Other Diagnosis:	ICD-10Code(s):			
3. REQUIRED CLINICAL INFORMATION PRIOR AUTHORIZATION. For diagnosis of mantle cell lymphom	I: PLEASE PROVIDE ALL RELEVANT CLINIO	CALINFORMATION TO SUPPORT A		
Has the patient had at least one prior * <i>Please submit documentation.</i>	therapy for mantle cell lymphoma?*	🗆 Yes 🗆 No		
Has the patient been previously treat (ibrutinib)?	ed with another Bruton tyrosine kinase	: (BTK) inhibitor such as Imbruvica		
For diagnosis of chronic lymphocytic leukemia(CLL) or small lymphocytic lymphoma(SLL): Has patient received any prior systemic therapies for CLL/SLL? u Yes u No				
	nbination with obinutuzumab(Gazyva@			
Has patient received at least one prio Will patient be using Calquence as Mo	r systemic therapy for CLL/SLL? Yes	No *Please submit documentation.		
Renewal Request:	a positive clinical response? 🗆 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 an information is received.	e covered on all plans. This request may	be denied unless all required		
the Health Plan, insurer, Medical Grou	n provided is true and accurate to the be p or its designees may perform a routine curacy of the information reported on th	e audit and request the medical		
Prescriber Signature or Electronic I.D.	Verification:	Date:		
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MANAGEMENT



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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



