PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Calquence® (acalabrutinib)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Calquence 100mg capsule

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Oral oncology partial fill program

Each fill of Calquence is limited to a 14-day supply at any network pharmacy. Patients are responsible for applicable deductible and copayments.

Drug cost information

The wholesale acquisition cost for one capsule is $281.28. The annual cost of treatment with this drug may be more than $202,521.6.

Precertification Requirements

Patient must meet all of the following criteria (supporting documentation is required):

1. Must have a diagnosis of Mantle cell lymphoma (MCL)
    a. Be at least 18 years of age or greater
    b. Documentation that the patient has previously received at least one prior therapy
    c. Must be used as monotherapy
    d. Must not have previously been treated with Bruton tyrosine kinase (BTK) inhibitor (i.e. ibrutinib) or BCL-2 inhibitor (i.e. venatoclax)

    OR

2. Must have a diagnosis of chronic lymphoid leukemia (CLL)/small lymphocytic lymphoma (SLL)
    a. Be at least 18 years of age or greater
    b. Must not have ibrutinib (Imbruvica)-refractory CLL/SLL with BTK C481S mutations

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2020

Last reviewed 01/2020

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

1. What condition is this drug being requested for?

- ☐ Mantle cell lymphoma
- ☐ Chronic lymphoid leukemia/Small lymphocytic lymphoma
- ☐ Other – the patient's condition is:_____

*Rationale:*_____

2. What previous treatment has the patient used?

(e.g. chemotherapy, Rituxan, Velcade, stem cell transplant)

Previous therapy: _____ Date: _____
Previous therapy: _____ Date: _____
Previous therapy: _____ Date: _____

3. Does the patient have ibrutinib (Imbruvica)-refractory CLL/SLL with BTK C481S mutation?

- ☐ Yes
- ☐ No

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