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.

Imbruvica® (ibrutinib)

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:
- ☐ Imbruvica 140mg tablet
- ☐ Imbruvica 280mg tablet
- ☐ Imbruvica 420mg tablet
- ☐ Imbruvica 560mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost per tablet is $405.00. The annual cost of treatment with this drug may be more than $163,000.

Precertification Requirements

Patient must meet the following criteria:

Must have a diagnosis of one of the following:

a. Chronic lymphocytic leukemia (with or without 17p chromosome deletion)
b. Small lymphocytic lymphoma (with or without 17p chromosome deletion)
c. Mantle cell lymphoma previously treated with at least one prior therapy
d. Marginal zone lymphoma previously treated with at least one anti-CD20-based therapy
e. Waldenström's macroglobulinemia
f. Classic chronic graft versus host disease (cGVHD) with all of the following:
    i. Greater than 3 organs involved, OR, any single organ with severity score[1] > 2, lung involvement, OR persistent thrombocytopenia (platelet count less than 100,000/microL)
    ii. Treatment failures with the following at optimized doses used in combination (failure indicated by disease progression in a previously unaffected organ, failure to improve after 1 month of combination therapy, inability to taper prednisone below 1mg/kg/day after 2 months, or patient is experiencing significant treatment-related toxicity):
        1. Systemic corticosteroid
        2. At least one additional immunosuppressant (e.g. tacrolimus, cyclosporine)
    iii. Initial approval granted for 12 weeks, with continued 3 month approvals authorized if the patient:

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 02/2019

Last reviewed 07/2018

1. Has documented (and sustains) at least a partial response (PR[2]) in at least one affected organ (with no progression in any other organ or site)

iv. Discontinuation is expected when patients no longer require treatment, indicated by a complete response (CR[2])

v. Approved dosing is 420 mg daily.

[1]Global Severity Grading of Chronic GvHD: NIH Consensus Criteria

[2]as defined per: Measuring Therapeutic Response in Chronic Graft-versus-Host Disease. National Institutes of Health Consensus Development Project on Criteria for Clinical Trials in Chronic Graft-versus-Host Disease: IV. The 2014 Response Criteria Working Group Report.

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?

- ☐ Chronic lymphocytic leukemia (with or without 17p chromosome deletion)
- ☐ Small lymphocytic lymphoma (with or without 17p chromosome deletion)
- ☐ Mantle cell lymphoma previously treated with at least one prior therapy
- ☐ Marginal zone lymphoma previously treated with at least one anti-CD20-based therapy
- ☐ Waldenström's macroglobulinemia
- ☐ Chronic graft versus host disease (cGVHD)
- ☐ Other – the patient's condition is:_____

2. For marginal zone lymphoma: 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. For cGVHD (new requests), please provide the following:

Diagnosis:

- ☐ Greater than 3 organs involved (specify) _____
- ☐ Any single organ (specify) with severity score > 2_____
- ☐ Lung involvement
- ☐ Persistent thrombocytopenia (provide platelet count)_____Date:_____

Current/Prior Therapies:

Drug & dose: _____Dates used:_____Response:_____
Drug & dose: _____Dates used:_____Response:_____
Drug & dose: _____Dates used:_____Response:_____

4. For cGVHD (continuation), please provide documentation to support all the following:

- ☐ Partial response (PR) in at least one affected organ (specify)_____
- ☐ No progression in any other organ or site

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Last reviewed 07/2018