# Priority Health Medicare prior authorization form

**Fax completed form to: 877.974.4411 toll free, or 616.942.8206**

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

# 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
- ☐ Imbruvica oral capsule

**Start date** (or date of next dose): _____
**Date of last dose** (if applicable): _____
**Dosing frequency:** _____

## Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

**For this drug to be covered, the patient must meet the following criteria:**

1. Must be used for a medically accepted indication*
2. For a diagnosis of GVHD:
   - Must fail one systemic corticosteroid ***AND*** one immunosuppressant (tacrolimus, cyclosporine)
   - *Failure is defined as disease progression, inability to taper steroid dose, or failure to improve after 1 month of therapy and/or treatment-related toxicity*
3. For a diagnosis of mantle cell lymphoma:
   - Must have prior use of one other treatment (e.g., cyclophosphamide, vincristine, doxorubicin, cytarabine, rituximab, etoposide, ifosfamide, carboplatin, cladribine)

**For continuation, the patient must meet all of the following requirements:**

1. For a diagnosis of GVHD:
   - Must have no disease progression of chronic GVHD, recurrent of malignancy, or unacceptable toxicity

## Additional information

**Note:** When criteria are met, initial approval for GVHD will be 12 weeks and subsequent approvals will be 12 months. For all other indications, approvals will be for 12 months.



**All fields must be complete and legible for review. Your office will receive a response via fax.** No changes made since 07/2018
Last reviewed 07/2018

## Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication for a drug or biologic used in an anti-cancer chemotherapeutic regimen is a use that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- supported by one of the following references (known as compendia): National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Micromedex DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology, or Lexi-Drugs
- — *or* — supported in peer-reviewed medical literature appearing in regular editions of approved publications

## New request
## Priority Health Precertification Documentation

**1. What condition is this drug being requested for?**

- ☐ Chronic lymphocytic leukemia
- ☐ Chronic lymphocytic leukemia with 17p deletion
- ☐ Small lymphocytic lymphoma
- ☐ Small lymphocytic lymphoma with 17p deletion
- ☐ Mantle cell lymphoma in a previously treated patient

**What previous treatment(s) has the patient used?**
(e.g. cyclophosphamide, vincristine, doxorubicin, cytarabine, rituximab, etoposide, etoposide, ifosfamide, carboplatin, cladribine.)

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

- ☐ Waldenström's macroglobulinemia
- ☐ Chronic graft-versus-host disease (GVHD) after failure of 1 or more lines of systemic therapy

**Has the patient failed therapy with one systemic corticosteroid?**
☐ Yes ☐ No. ***Rationale for use:*** _____

**Has the patient failed therapy with one immunosuppressant (e.g., tacrolimus, cyclosporine)?**
☐ Yes ☐ No. ***Rationale for use:*** _____

- ☐ Other – the patient's condition is: _____

## Continuation
## Priority Health Precertification Documentation

**1. What condition is this drug being requested for?**

- ☐ Chronic lymphocytic leukemia
- ☐ Chronic lymphocytic leukemia with 17p deletion
- ☐ Small lymphocytic lymphoma
- ☐ Small lymphocytic lymphoma with 17p deletion
- ☐ Mantle cell lymphoma in a previously treated patient
- ☐ Waldenström's macroglobulinemia
- ☐ Chronic graft-versus-host disease (GVHD) after failure of 1 or more lines of systemic therapy

**Has the patient had disease progression, recurrence of malignancy, or unacceptable toxicity?**
☐ No ☐ Yes. ***Rationale for use:*** _____

- ☐ Other – the patient's condition is: _____


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Last reviewed 07/2018

**Priority Health** Medicare exception request

**Do you believe one or more of the prior authorization requirements should be waived?** ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

**Would Imbruvica likely be the most effective option for this patient?**
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

**If the patient is currently using Imbruvica, would changing the patient's current regimen likely result in adverse effects for the patient?**
☐ Yes ☐ No
If yes, please explain: _____

_____

_____


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Last reviewed 07/2018