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.

Venclexta™ (venetoclax)

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:
- ☐ Venclexta Starting Pack
- ☐ Venclexta 10 mg tablet
- ☐ Venclexta 50 mg tablet
- ☐ Venclexta 100 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Oral oncology partial fill program

With the exception of the Venclexta starting pack, each fill of Venclexta is limited to a 14-day supply at any network pharmacy. Patients are responsible for applicable deductable and copayments.

Drug cost information

The wholesale acquisition cost for one tablet is $92.91. The annual cost of treatment with this drug may be more than $133,000.

Precertification Requirements

Patient must meet the following criteria:

1. Must have chronic lymphocytic leukemia or Small Lymphocytic LymphomaMust have received at least one prior treatment

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.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 11/2018
Last reviewed 11/2018

Priority Health Precertification Documentation

1. What condition is this drug being requested for?

- ☐ Chronic lymphocytic leukemia
- ☐ Small Lymphocytic Lymphoma
- ☐ Other – the patient's condition is: _____

2. What previous treatment has the patient used?
(e.g. chemotherapy, Rituxan, Velcade, Imbruvica)

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

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