Prescriber Criteria Form Imbruvica 2024 PA Fax 1050-A v5 010124.docx Imbruvica (ibrutinib) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Imbruvica (ibrutinib).

Drug Name: Imbruvica (ibrutinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have any of the following diagnoses: A) chronic lymphocytic leukemia (CLL), B) small lymphocytic lymphoma (SLL)? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of mantle cell lymphoma? [If no, then skip to question 6.]	Yes	No
3	Will the requested drug be used as second-line or subsequent therapy? [If yes, then no further questions.]	Yes	No
4	Will the requested drug be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (rituximab, cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen? [If yes, then no further questions.]	Yes	No
5	Will the requested drug be used as aggressive induction therapy? [No further questions.]	Yes	No
6	Does the patient have any of the following diagnoses: A) Waldenstrom's macroglobulinemia, B) lymphoplasmacytic lymphoma? [If yes, then no further questions.]	Yes	No
7	Does the patient have a diagnosis of marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of	Yes	No

	nongastric sites, nodal marginal zone lymphoma, and splenic marginal zone lymphoma)? [If no, then skip to question 9.]		
8	Will the requested drug be used as second-line or subsequent therapy? [No further questions.]	Yes	No
9	Does the patient have a diagnosis of chronic graft-versus-host disease (cGVHD)? [If no, then skip to question 11.]	Yes	No
10	Did the patient fail one or more lines of systemic therapy? [No further questions.]	Yes	No
11	Does the patient have a diagnosis of hairy cell leukemia? [If no, then skip to question 13.]	Yes	No
12	Will the requested drug be used as a single agent for disease progression? [No further questions.]	Yes	No
13	Does the patient have a diagnosis of primary central nervous system lymphoma? [If no, then skip to question 16.]	Yes	No
14	Is the disease relapsed or refractory? [If yes, then no further questions.]	Yes	No
15	Will the requested drug be used for induction therapy as a single agent? [No further questions.]	Yes	No
16	Does the patient have any of the following diagnoses: A) diffuse large B-cell lymphoma, B) high-grade B-cell lymphoma? [If no, then skip to question 18.]	Yes	No
17	Will the requested drug be used as second-line or subsequent therapy? [No further questions.]	Yes	No
18	Does the patient have a diagnosis of human immunodeficiency virus (HIV)-related B-cell lymphoma? [If no, then skip to question 22.]	Yes	No
19	Will the requested drug be used as a single agent? [If no, then no further questions.]	Yes	No
20	Is the disease relapsed? [If no, then no further questions.]	Yes	No
21	Will the requested drug be used as second-line or subsequent therapy? [No further questions.]	Yes	No
22	Is the requested drug being used for post-transplant lymphoproliferative disorders? [If no, then no further questions.]	Yes	No

23	Will the requested drug be used in patients who have received prior chemoimmunotherapy?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____