{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} Date: {{TODAY}}
Patient's ID: {{MEMBERID}} Patient's Date of Birth: {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} Patient Phone: <<MEMPHONE>>
Specialty: _____ NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} Physician Office Fax: {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ Frequency: _____ Strength: _____
Route of Administration: _____ Expected Length of Therapy: _____
Diagnosis: <<DIAGNOSIS>> ICD Code: <<ICD9>>

1. What is the diagnosis?
   - ❑ Mantle cell lymphoma (MCL)
   - ❑ Hairy Cell Leukemia
   - ❑ Waldenstrom Macroglobulinemia (WM)/Lymphoplasmacytic lymphoma/Bing-Neel Syndrome (LL)
   - ❑ Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)
   - ❑ Gastric mucosa-associated lymphoid tissue (MALT) Lymphoma (extranodal marginal zone lymphoma of the stomach)
   - ❑ Non-Gastric MALT Lymphoma (extranodal marginal zone lymphoma of nongastric sites)
   - ❑ Nodal Marginal Zone Lymphoma
   - ❑ Splenic Marginal Zone Lymphoma ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #5*
4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No
5. What is the requested regimen?
   - ❑ Single agent
   - ❑ As a component of TRIANGLE regimen [alternating RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone) + Brukinsa/RDHAP (rituximab, dexamethasone, and cytarabine) + platinum (carboplatin, cisplatin, or oxaliplatin)],
   - ❑ In combination with rituximab
   - ❑ Other:_____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Mantle Cell Lymphoma (MCL)
1. Has the patient received at least one prior therapy? ❑ Yes ❑ No
2. Does the patient have TP53 mutations? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming TP53 mutations.*** ❑ Yes ❑ No ❑ Unknown
3. What is the place in therapy in which the requested drug will be used?
   ❑ Induction therapy ❑ Maintenance therapy ❑ No

4. Will the requested medication be used as maintenance therapy? ❑ Yes ❑ No

Section B: Gastric MALT Lymphoma, Non-Gastric MALT Lymphoma, Nodal Marginal Zone Lymphoma, Splenic Marginal Zone Lymphoma

1. Has the patient received an anti-CD20 based-regimen (e.g., rituximab or obinutuzumab)? ❑ Yes ❑ No

2. What is the place in therapy in which the requested drug will be used? *No further questions*
   ❑ First-line therapy
   ❑ Subsequent therapy

Section D: Hairy Cell Leukemia

1. Has the patient had disease progression after receiving therapy for relapsed or refractory disease?
   ❑ Yes ❑ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date