{{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 patient's diagnosis?
   - ❑ Mantle cell lymphoma (MCL)
   - ❑ Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL)
   - ❑ Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma (WM/LPL)/Bing-Neel syndrome
   - ❑ Marginal zone lymphoma (such as extranodal [gastric or non-gastric MALT lymphoma], marginal zone lymphoma, nodal or splenic marginal zone lymphoma) (MZL)
   - ❑ Chronic graft-versus-host disease (cGVHD)
   - ❑ Hairy cell leukemia
   - ❑ Central nervous system cancers
   - ❑ Diffuse large B-cell lymphoma
   - ❑ High-grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified)
   - ❑ HIV-related B-cell lymphomas
   - ❑ Monomorphic post-transplant lymphoproliferative disorders
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this a request for continuation of therapy 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 *No further questions*
5. In which of the following regimens will the requested medication be used? ***Indicate ALL that apply.***
   - ❑ The requested medication as a single agent
   - ❑ The requested medication in combination with rituximab
   - ❑ The requested medication in combination with obinutuzumab
   - ❑ The requested medication in combination with venetoclax
   - ❑ The requested medication in combination with high-dose methotrexate and rituximab
   - ❑ As a component of TRIANGLE regimen: alternating RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone) + covalent Bruton tyrosine kinase inhibitor (ibrutinib)/RDHA (rituximab, dexamethasone, and cytarabine) + carboplatin regimen
   - ❑ Other _____

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

Section A: Mantle Cell Lymphoma (MCL)

6. Will the requested drug be used as pretreatment to induction therapy with RHyperCVAD (rituximab, cyclophosphamide, vincristine, doxorubicin, and dexamethasone)?
   If Yes, no further questions. ❑ Yes ❑ No

7. Has the patient received at least one prior therapy for mantle cell lymphoma? ❑ Yes ❑ No

8. Will the requested medication be used as aggressive induction therapy? ❑ Yes ❑ No

Section B: Marginal zone lymphoma (MZL) (such as extranodal [gastric or non-gastric MALT lymphoma], marginal zone lymphoma, nodal or splenic marginal zone lymphoma)

9. Has the patient received at least one prior therapy for marginal zone lymphoma (MZL)? ❑ Yes ❑ No

Section C: Chronic Graft-Versus-Host Disease (cGVHD)

10. Has the patient failed at least one or more lines of therapy? ❑ Yes ❑ No

Section D: Hairy Cell Leukemia

11. What is the clinical setting in which the requested medication will be used?
    ❑ Relapsed disease
    ❑ Refractory disease
    ❑ Other _____

12. Will the requested medication be used as a single agent for disease progression? ❑ Yes ❑ No

Section E: Central Nervous System Cancers

13. Which of the following applies to the patient's disease?
    ❑ Primary central nervous system lymphoma
    ❑ Brain metastases in lymphoma
    ❑ Other _____

14. Is the patient's disease relapsed or refractory? *If Yes, no further questions.* ❑ Yes ❑ No

15. Will the requested medication be used for induction therapy? ❑ Yes ❑ No

Section F: Diffuse large B-cell lymphoma, High-grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified), HIV-related B-cell lymphomas, Monomorphic post-transplant lymphoproliferative disorders

16. What is the place in therapy in which the requested medication will be used?
    ❑ First-line treatment
    ❑ Subsequent therapy

17. Is the patient a candidate for transplant? ❑ 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