Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

{{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?
   - ❑ Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)
   - ❑ Acute myeloid leukemia (AML), newly-diagnosed
   - ❑ Acute myeloid leukemia (AML), relapsed or refractory
   - ❑ Mantle cell lymphoma (MCL)
   - ❑ Blastic plasmacytoid dendritic cell neoplasm (BPDCN)
   - ❑ Multiple myeloma (MM)
   - ❑ Systemic light chain amyloidosis (SLCA)
   - ❑ Waldenström macroglobulinemia/lymphoplasmacytic lymphoma (WM/LPL)
   - ❑ Myelodysplastic syndrome (MDS)
   - ❑ Hairy cell leukemia
   - ❑ Myeloproliferative neoplasms
   - ❑ B-cell acute lymphoblastic leukemia/T-cell acute lymphoblastic leukemia (B-ALL/T-ALL)
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this a request for continuation of therapy with the requested drug?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*
4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No

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

Section A: Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL)
Continuation

1. What is the prescribed regimen?
   - ❑ The requested drug as monotherapy, *no further questions.*
   - ❑ In combination with rituximab (Rituxan)
   - ❑ In combination with obinutuzumab (Gazyva)*, skip to #3*
   - ❑ Other _____
2. How many months has the patient received the requested drug in combination with rituximab (Rituxan) (starting with cycle 1, day 1 of rituximab initiation)? _____ months *No further questions.*
3. How many cycles of the requested drug has the patient received in combination with obinutuzumab (Gazyva) therapy? _____ cycle(s) *No further questions.*

Initiation

4. What is the prescribed regimen?
   - ❑ The requested drug will be used as monotherapy
   - ❑ In combination with rituximab (Rituxan)
   - ❑ In combination ith obinutuzumab (Gazyva)
   - ❑ Other _____

Section B: Acute Myeloid Leukemia (AML), Newly-Diagnosed

1. What is the prescribed regimen? *If patient is greater than or equal to 75 years old, no further questions.*
   - ❑ In combination with decitabine
   - ❑ In combination with azacitidine
   - ❑ In combination with low-dose cytarabine
   - ❑ Other _____
2. *If the patient is less than 75 years old,* is the patient a candidate for intensive remission induction therapy with unfavorable-risk cytogenetics?
   If Yes, no further questions ❑ Yes ❑ No ❑ NA, patients age not applicable
3. Does the patient have comorbidities that preclude the use of intensive induction chemotherapy?
   If Yes, no further questions. ❑ Yes ❑ No
4. Is the patient a candidate for intensive induction therapy? ❑ Yes ❑ No
5. Does the patient have poor/adverse risk disease? ❑ Yes ❑ No
6. Will the requested drug be used in a post-induction therapy regimen following response to a Venclexta-based regimen? ❑ Yes ❑ No

Section C: Acute Myeloid Leukemia (AML), Relapsed or Refractory

1. What is the prescribed regimen?
   - ❑ In combination with decitabine
   - ❑ In combination with azacitidine
   - ❑ In combination with low-dose cytarabine
   - ❑ Other _____

Section D: Mantle Cell Lymphoma (MCL)

1. How will the requested drug be used?
   ❑ Subsequent treatment ❑ Induction therapy, *skip to #3* ❑ Other _____
2. What is the prescribed regimen?
   - ❑ Single agent
   - ❑ In combination with rituximab (Rituxan)
   - ❑ In combination with ibrutinib (Imbruvica)
   - ❑ Other _____
3. Does the disease have a positive TP53-mutation? ***ACTION REQUIRED, If Yes, please attach supporting chart note(s) or test results confirming TP53- mutation status.*** ❑ Yes ❑ No ❑ Unknown
4. Will the requested drug be used in combination with Gazyva (obinutuzumab) and Brukinsa (zanubrutinib)?
   ❑ Yes ❑ No

Section E: Blastic Plasmacytoid Dendritic Cell Neoplasm (BPDCN)

1. What is the prescribed regimen?
   - ❑ In combination with decitabine
   - ❑ In combination with azacitidine
   - ❑ In combination with low-dose cytarabine
   - ❑ Other _____

Section F: Multiple Myeloma (MM)

1. What is the clinical setting in which the requested drug will be used?
   ❑ Relapsed disease ❑ Refractory disease ❑ Other _____
2. Does the patient have a documented translocation t(11,14)? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of translocation t(11;14).*** ❑ Yes ❑ No ❑ Unknown
3. What is the prescribed regimen?
   - ❑ In combination with dexamethasone
   - ❑ In combination with dexamethasone with daratumumab
   - ❑ In combination with dexamethasone and daratumumab and hyaluronidase-fihj
   - ❑ In combination with dexamethasone and a proteasome inhibitor (e.g. bortezomib, carfilzomib, ixazomib)
   - ❑ Other _____

Section G: Systemic Light Chain Amyloidosis (SLCA)

1. What is the clinical setting in which the requested drug will be used?
   ❑ Relapsed disease ❑ Refractory disease ❑ Other _____
2. Does the patient have a documented translocation t(11,14)? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of translocation t(11;14).*** ❑ Yes ❑ No ❑ Unknown
3. What is the prescribed regimen?
   ❑ Single agent ❑ In combination with dexamethasone ❑ Other _____

Section H: Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma (WM/LPL)

1. Will the requested drug be used as subsequent therapy? ❑ Yes ❑ No
2. Will the requested medication be used as a single agent? ❑ Yes ❑ No

Section I: Myelodysplastic Syndrome (MDS)

1. What is the prescribed regimen?
   ❑ The requested medication with azacitidine
   ❑ The requested medication with decitabine
   ❑ Other _____

Section J: Hairy Cell Leukemia

1. What is the prescribed regimen?
   ❑ Single agent
   ❑ In combination with rituximab
   ❑ Other _____
2. What is the clinical setting in which the requested drug will be used?
   ❑ Relapsed disease ❑ Refractory disease ❑ Other _____
3. Has the patient experienced disease progression on previous therapy? ❑ Yes ❑ No
4. Is the disease resistant to BRAF inhibitor therapy? ❑ Yes ❑ No

Section K: Myeloproliferative Neoplasms

1. Has the patient experienced disease progression of accelerated/blast phase myeloproliferative neoplasms?
   ❑ Yes ❑ No
2. Will the requested drug be used in combination with azacitidine or decitabine?
   ❑ Yes, in combination with azacitidine ❑ Yes, in combination with decitabine ❑ No
3. What is the clinical setting in which the requested drug will be used?
   ❑ Relapsed disease ❑ Refractory disease ❑ Other _____
4. What is the prescribed regimen?
   ❑ In combination with vincristine, pegaspargase and prednisone
   ❑ In combination with vincristine, pegaspargase and dexamethasone
   ❑ In combination with vincristine, calaspargase and prednisone
   ❑ In combination with vincristine, calaspargase and dexamethasone
   ❑ Other _____

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