BlueCross BlueShield Federal Employee Program®

CALQUENCE
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Calquence (acalabrutinib)

***Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

Will the patient need more than 200 milligrams per day? ❑Yes* ❑No

If YES, please specify the requested milligrams per day: _____ mg per day

1. Has the patient been on Calquence continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Chronic lymphocytic leukemia (CLL) **OR** ❑Small lymphocytic lymphoma (SLL)

i. Will Calquence be used as a single agent? ❑Yes ❑No

ii. Will Calquence be used in combination with Gazyva (obinutuzumab) as first line therapy? ❑Yes ❑No

❑Mantle cell lymphoma (MCL)

i. Is the patient treatment naive or has the patient been previously treated for mantle cell lymphoma (MCL)? ***Please select answer below:***

❑**Treatment naïve** mantle cell lymphoma (MCL), please answer the following questions:

1) Is the patient ineligible for autologous hematopoietic stem cell transplantation (HSCT)?

❑Patient is ineligible for HSCT ❑Patient is eligible for HSCT

2) Will this medication be used in combination with bendamustine and rituximab (Rituxan)? ❑Yes ❑No

❑**Previously treated** mantle cell lymphoma (MCL), please answer the following questions:

1) Will this medication be used as a single agent? ❑Yes ❑No

2) Has the patient received at least one prior therapy? ❑Yes ❑No

❑Other diagnosis ***(please specify):*** _____

b. Does the prescriber agree to perform a baseline CBC and monitor monthly during therapy? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Chronic lymphocytic leukemia (CLL)

❑Mantle cell lymphoma (MCL)

❑Small lymphocytic lymphoma (SLL)

❑Other diagnosis ***(please specify):*** _____

b. Does the prescriber agree to monitor CBC monthly during therapy? ❑Yes ❑No

c. Has the patient experienced disease progression or unacceptable toxicity while on Calquence? ❑Yes ❑No

2. Does the prescriber agree to monitor for malignancies during therapy? ❑Yes ❑No

3. Does the prescriber agree to monitor for bleeding during therapy? ❑Yes ❑No