

US Family Health Plan
Prior Authorization Request Form for
acalabrutinib (**Calquence**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Is the patient GREATER THAN or EQUAL to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Does the patient have pathologically confirmed mantle cell lymphoma, with documentation of monoclonal B cells that have a chromosome translocation t(11;14) (q13;q32) and/or overexpress cyclin D1?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No Proceed to question 4
3. Does the patient have significant cardiovascular disease such as uncontrolled or symptomatic arrhythmias, congestive heart failure, or myocardial infarction within 6 months of screening, or any Class 3 or 4 cardiac disease as defined by the New York Heart Association Functional Classification, or corrected QT interval (QTc) GREATER THAN 480 msec?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Sign and date below
4. Please provide the diagnosis.	_____ Proceed to question 5	
5. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

_____ Prescriber Signature	_____ Date
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