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 855-273-5735

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?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is Calquence being prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have pathologically confirmed relapsed or refractory mantle cell lymphoma (MCL), with documentation of monoclonal B cells that have a chromosome translocation t(11;14)(q13;q32) and/or overexpress cyclin D1 that has a short response duration to prior therapy (less than median progression free survival [PFS])?	☐ Yes Proceed to question **11**	☐ No Proceed to question **4**
4. Does the patient have a diagnosis of frontline or relapsed refractory therapy for chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)?	☐ Yes Proceed to question **5**	☐ No Proceed to question **7**
5. Does the patient have CLL/SLL with del(17p)/TP53 mutation?	☐ Yes Proceed to question **9**	☐ No Proceed to question **6**
6. Does the patient fit into any of the following categories? ○ Younger than 65 years of age ○ 65 years of age or older with significant comorbidities ○ Frail patient with significant comorbidities (not able to tolerate purine analogs)	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**

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7. Please provide the diagnosis.	_____ Proceed to question **8**	
8. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
9. Does the patient have evidence of a BTK C481S mutation?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Does the patient have prior ibrutinib-refractory disease?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**
11. 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?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Will the patient be monitored for bleeding, infection, cardiac arrhythmias, and cytopenias?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. What is the patient's age/gender?	☐ **Male - Sign and date below** ☐ **Female of childbearing potential -** Proceed to question **14** ☐ **Female not of childbearing potential - Sign and date below**	
14. Has the patient been advised of the risk of significant fetal harm?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Is the patient breastfeeding?	☐ Yes Proceed to question **16**	☐ No **Sign and date below**
16. Has it been confirmed that patients will not breastfeed during treatment and for at least 2 weeks following cessation of treatment?	☐ Yes **Sign and date below**	☐ 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