US Family Health Plan
Prior Authorization Request Form for
Ibrutinib (Imbruvica)

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**

Clinical documentation may be required for approval

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. Does the prescriber acknowledge that Imbruvica capsules are more cost-effective for DoD than the Imbruvica tablets at the 140 and 280 mg strengths?	☐ Acknowledged Proceed to question **2**	
2. What is the requested medication?	☐ Imbruvica capsules or suspension Proceed to question **6**	☐ Imbruvica tablets Proceed to question **3**
3. What is the requested strength?	☐ 140 or 280 mg Proceed to question **4**	☐ Other strength Proceed to question **6**
4. Imbruvica capsules are more cost-effective for DoD than the Imbruvica tablets at the 140 and 280 mg strengths. Will the prescription be changed to the capsule formulation for these strengths?	☐ Yes Proceed to question **6**	☐ No Proceed to question **5**
5. Please state why the patient cannot take multiple capsules (70 mg or 140 mg capsules) to achieve the patient's daily dose.	_____ Proceed to question **6**	
6. Is Imbruvica being prescribed by or in consultation with a hematologist/oncologist?	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved

7. Is the patient GREATER THAN or EQUAL to 18 years of age?	☐ Yes Proceed to question **10**	☐ No Proceed to question **8**
8. Is the patient greater than or equal to 1 year(s) of age?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. Does the patient have a diagnosis of chronic graft-versus-host disease?	☐ Yes Proceed to question **16**	☐ No Proceed to question **14**
10. For which indication is Imbruvica being prescribed?	☐ Pretreatment to limit the number of cycles of RhyperCVAD/rituximab maintenance therapy for Mantle Cell Lymphoma – Proceed to question **16** ☐ Second line (or subsequent therapy) for Mantle Cell Lymphoma – Proceed to question **16** ☐ Second line (or subsequent therapy) for Marginal Zone Lymphoma – Proceed to question **16** ☐ Second line (or subsequent therapy) for non-germinal center B cell-like Diffuse Large B cell Lymphoma – Proceed to question **11** ☐ Front line or relapsed refractory therapy for chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) – Proceed to question **12** ☐ Waldenstroms macroglobulinemia – Proceed to question **16** ☐ Chronic graft vs host disease - Proceed to question **16** ☐ Other indication – Proceed to question **14**	
11. Is the patient unable to receive chemotherapy?	☐ Yes Proceed to question **16**	☐ No **STOP** Coverage not approved
12. Does the patient have the del(17p)/TP53 mutation?	☐ Yes Proceed to question **16**	☐ No Proceed to question **13**
13. 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 **16**	☐ No **STOP** Coverage not approved
14. Please provide the diagnosis.	_____ Proceed to question **15**	

15. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **16**	☐ No **STOP** Coverage not approved
16. Will the patient be monitored for bleeding, infection, hypertension, cardiac arrhythmias, cytopenias, and Tumor Lysis Syndrome?	☐ Yes Proceed to question **17**	☐ No **STOP** Coverage not approved
17. Is the patient of reproductive age?	☐ Yes Proceed to question **18**	☐ No **Sign and date below**
18. What is the patient's gender?	☐ Male Proceed to question **25**	☐ Female Proceed to question **19**
19. Does the patient agree to use effective contraception during treatment and for at least 30 days after discontinuation?	☐ Yes Proceed to question **20**	☐ No **STOP** **Coverage not approved**
20. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **21**
21. Has it been confirmed that the patient is not pregnant by negative hCG (human chorionic gonadotropin)?	☐ Yes Proceed to question **22**	☐ No **STOP** **Coverage not approved**
22. Is the patient planning to become pregnant?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **23**
23. Is the patient breastfeeding?	☐ Yes Proceed to question **24**	☐ No Proceed to question **25**
24. Has the patient been advised that the potential harm to the infant is unknown?	☐ Yes Proceed to question **25**	☐ No **STOP** Coverage not approved
25. Will the patients of reproductive potential use effective contraception during treatment and for at least 30 days after discontinuation?	☐ 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 _____