US Family Health Plan
Prior Authorization Request Form for
venetoclax **(Venclexta)**

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 the requested medication being prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. For which indication is the requested medication being prescribed?	☐ **Frontline therapy for chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) without del(17p)/TP53 mutation** - Proceed to question **4** ☐ **Relapsed/refractory therapy for CLL/SLL without del(17p)/TP53 mutation** - Proceed to question **5** ☐ **Frontline or relapsed/refractory therapy for CLL/SLL with del(17p)/TP53 mutation** - Proceed to question **10** ☐ **Patient has newly diagnosed acute myeloid leukemia (AML) and is a candidate for intensive remission induction therapy** - Proceed to question **6** ☐ **Patient has newly diagnosed AML and is not a candidate for intensive remission induction therapy** - Proceed to question **7** ☐ **Patient has completed lower-intensity induction therapy for AML with a response** - Proceed to question **7** ☐ **Patient has relapsed refractory AML** - Proceed to question **10** ☐ **Other** - Proceed to question **8**	

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4. Will the requested medication be used in combination with obinutuzumab (Gazyva) infusion?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. 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 **10**	☐ No **STOP** **Coverage not approved**
6. Does the patient have unfavorable-risk cytogenetics (exclusive of AML with myelodysplasia-related changes)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the patient greater than or equal to 60 years of age?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
8. Please provide the diagnosis.	_____ Proceed to question **9**	
9. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Will the requested medication be titrated to therapeutic dose in consideration of tumor lysis syndrome (TLS)?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the requested medication be concomitantly used at initiation or during ramp-up with a strong CYP3A inhibitor?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Will the patient be provided prophylaxis and monitored for tumor lysis syndrome (TLS) (based on tumor burden-defined risk)?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Will the patient be monitored for neutropenia?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**

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14. Will the patient be monitored for signs and symptoms of infection?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Will the patient be administered live attenuated vaccines prior to, during, or after treatment with Venclexta until B-cell recovery occurs?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **16**
16. What is the patient's age/gender?	☐ **Male** - Proceed to question **20** ☐ **Female of reproductive potential** - Proceed to question **17** ☐ **Female not of reproductive potential - Sign and date below**	
17. Does the patient agree to use effective contraception during treatment and for at least 30 days after discontinuation?	☐ Yes Proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Is the patient pregnant or planning to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **19**
19. Will the patient breastfeed during treatment?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
20. Are patients informed that Venclexta may cause male infertility?	☐ 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 _____