

**Brukina<sup>®</sup> (Zanubrutinib) Prior Authorization Form**

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

**Drug Information**

**Pharmacy billing (NDC:** \_\_\_\_\_ **) Start Date (or date of next dose):** \_\_\_\_\_

**Dose:** \_\_\_\_\_ **Dosing Regimen:** \_\_\_\_\_

**Billing Provider Information**

**Pharmacy NPI:** \_\_\_\_\_ **Pharmacy Name:** \_\_\_\_\_

**Pharmacy Phone:** \_\_\_\_\_ **Pharmacy Fax:** \_\_\_\_\_

**Prescriber Information**

**Prescriber NPI:** \_\_\_\_\_ **Prescriber Name:** \_\_\_\_\_

**Prescriber Phone:** \_\_\_\_\_ **Prescriber Fax:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_

**Criteria**

**For Initial Authorization:**

**1. Please indicate the diagnosis and information:**

☐ **Mantle Cell Lymphoma (MCL)**

A. Has member received at least 1 prior therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

☐ **Marginal Zone Lymphoma (MZL)**

A. Has member received at least 1 prior anti-CD20 monoclonal antibody-based therapy?

Yes \_\_\_\_\_ No \_\_\_\_\_

☐ **Waldenström's Macroglobulinemia**

A. Will Brukina<sup>®</sup> be used as primary therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

B. Will Brukina<sup>®</sup> be used as subsequent therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

☐ **If diagnosis is not listed above, please indicate diagnosis:** \_\_\_\_\_

**Additional Information:** \_\_\_\_\_

**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_

2. Does patient have any evidence of progressive disease while on zanubrutinib therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

3. Has the member experienced any adverse drug reactions related to zanubrutinib therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

*If yes, please specify adverse reactions:* \_\_\_\_\_

**Additional Information:** \_\_\_\_\_

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.***

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization Unit

Fax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4

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