

Calquence® (acalabrutinib) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Pharmacy Billing (NDC: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

Pharmacy 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. Will acalabrutinib be used as a single agent? Yes ___ No ___

Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)

A. Will acalabrutinib be used as a single agent? Yes ___ No ___

B. Will acalabrutinib be used in combination with obinutuzumab? Yes ___ No ___

Other _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on acalabrutinib? Yes ___ No ___

3. Has the member experienced any adverse drug reactions related to acalabrutinib 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. Please do not send in chart notes. Specific information will be requested if necessary. 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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