OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Imbruvica® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic lymphocytic leukemia (CLL)
❑ Chronic graft versus host disease (cGVHD)
❑ Mantle cell lymphoma (MCL)
❑ Other diagnosis: _____ ICD-10 Code(s): _____
❑ Marginal zone lymphoma (MZL)
❑ Small lymphocytic lymphoma (SLL)
❑ Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma

Prescriber's Specialty:

Select if Imbruvica is prescribed by or in consultation with one of the following specialists:
❑ Hematologist ❑ Oncologist ❑ Physician experienced in the management of transplant patients

For chronic graft versus host disease, answer the following:

Has the patient had trial and failure of at least one or more lines of systemic therapy (e.g., corticosteroids, mycophenolate)? ❑ **Yes** ❑ **No**

For mantle cell lymphoma (MCL), answer the following:

Has the patient received at least one prior therapy for MCL (e.g., Rituxan [rituximab])? ❑ **Yes** ❑ **No**

For marginal zone lymphoma (MZL), answer the following:

Has the patient received at least one prior anti-CD20-based therapy for MZL [e.g., Rituxan (rituximab), Zevalin (ibritumomab), Gazyva (obinutuzumab), etc.]? ❑ **Yes** ❑ **No**

Reauthorization:
If this is a reauthorization request, answer the following question:

Does the patient show evidence of progressive disease while on Imbruvica therapy? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.