State of Oklahoma
SoonerCare
Venclexta® (Venetoclax) Prior Authorization Form

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

Drug Information

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

Dose:_____ ***Regimen:***_____

Billing Provider Information

Provider NPI:_____ ***Provider Name:***_____

Provider Phone:_____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Criteria

For Initial Authorization:

1. Will venetoclax be used as a single-agent? Yes☐ No☐
2. Will venetoclax be used as first-line therapy? Yes☐ No☐
3. Will venetoclax be used as second-line or subsequent therapy? Yes☐ No☐
4. Will venetoclax be used for relapsed or refractory disease? Yes☐ No☐
5. Please indicate the diagnosis and information:
   - ❑ **Mantle Cell Lymphoma (MCL)**
   - ❑ **Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)**
     - A. Will venetoclax be used in combination with obinutuzumab? Yes☐ No☐
       - i. If "Yes", please completely fill out and submit the Gazyva® (obinutuzumab) Prior Authorization Form (Pharm-100) that is available on the OHCA website: www.okhca.org.
     - B. Will venetoclax be used in combination with rituximab? Yes☐ No☐
   - ❑ **Acute Myeloid Leukemia (AML)**
     - A. Will venetoclax be used in combination with azacitidine, or decitabine, or low-dose cytarabine? Yes☐ No☐
     - B. Is member younger than 75 years of age and unable to tolerate intensive induction chemotherapy? Yes☐ No☐
   - ❑ **If diagnosis is not listed above, please indicate diagnosis**:_____

Additional Information:_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on venetoclax? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to venetoclax 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:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*