PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM

For cancer therapy: Imbruvica (ibrutinib)

Please fax form to: 1-866-840-1509

Please note that the patient **AND** physician must complete this form. **All fields are mandatory and must be completed. Incomplete forms may result in your application being declined.** Please retain a copy of this form for your records.

Instructions:

1. **PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.**
2. The patient/plan member must complete section A.
3. Your physician must complete section B. The cost, if any, of completing this form is at the expense of the patient/plan member.
4. Please return the form to your insurance company via Pharmacy Services at TELUS Health (a service provider of your insurance company) by fax to **1-866-840-1509**.
5. If you have any questions on the application of this program or the decision on reimbursement, or to inquire on the status of your Reimbursement Request Form, please contact your insurer.

A. Information to be Completed by the Patient

Member's or Insured's Name	Drug Card Number __ __ - __ __ __ __ __ __ - __ __ __ __ __ __ __ __ __ __ - __ __	
Patient's Name	Patient's Date of Birth (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	Relationship to Member/Insured ❑Member ❑Spouse ❑Dependent

Please allow two business days for a response once all information is received and complete.
Notification of the results of this request will occur Monday to Friday between 9 a.m. and 4 p.m. Eastern Time.

Please provide contact information and indicate **ONE** method of preferred contact for notification of the results:

❑ E-mail me at:	❑ Call me (and leave a message if I'm not there) at:	❑ Fax me at:
❑ Contact my pharmacy: Pharmacy Name		Pharmacy Phone Number

I certify that the information provided by me is true, correct and complete to the best of my knowledge. I authorize my insurance company, TELUS Health (a service provider of my insurance company), their authorized representatives, agents and service providers to use and exchange this information needed for underwriting, administration and paying claims with any person or organization who has relevant information pertaining to this claim including health professionals, institutions and investigative agencies in the event of an audit. I authorize my insurance company and/or TELUS Health (a service provider of my insurance company) to contact any licensed physician, institution, pharmacy or person who has any records or knowledge of me or my health with respect to this submitted claim.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN _____

Date: (DD/MMM/YYYY): __ __ / __ __ __ / __ __ __ __

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B. Information to be Completed by Prescribing Physician

Drug Name	Strength	Dose
Imbruvica (ibrutinib)		

Imbruvica (ibrutinib) will be eligible for reimbursement only if the patient satisfies the conditions listed below and if the patient does not qualify for coverage under any other drug plan or government mandated program. If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. If "None of the above criteria" is indicated, the patient will not be eligible for reimbursement. **For Quebec plan members, please refer to the RAMQ exception drug criteria, if applicable.**

Eligibility Criteria

Please indicate if the patient satisfies one of the following criteria:

- ❑ A diagnosis of chronic lymphocytic leukemia (CLL) (92814006), where the physician confirms the patient meets the drug's Health Canada approved indication for treatment of patients with CLL
  - ❑ Be used in patients with previously untreated active CLL; **OR**
  - ❑ Be used in patients with CLL that have received at least one prior therapy; **OR**
  - ❑ Be used in combination with bendamustine and rituximab for patients with CLL who have received at least one prior therapy; **OR**
  - ❑ Be used in combination with obinutuzumab for the treatment of patients with previously untreated active CLL; **AND**
    - ❑ Adequate hematologic function independent of transfusion and growth factor support; **AND**
    - ❑ Adequate hepatic and renal function; **AND**
    - ❑ Men and women ≥ 18 years of age; **AND**
    - ❑ Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2; **AND**
    - ❑ Measurable nodal disease by computed tomography (CT), defined as at least 1 lymph node >1.5 cm in the longest diameter in a site that has not been previously irradiated

  OR
  - ❑ Be used in combination with rituximab for patients with previously untreated CLL; **AND** meets <u>all</u> of the following
    - ❑ Confirmed diagnosis of CLL according to the National Cancer Institute (NCI)/International Workshop on Chronic Lymphocytic Leukemia (IWCLL) criteria
    - ❑ Evidence of symptomatic/objective signs of <u>active</u> CLL (e.g. progressive bone marrow failure as manifested by the development of worsening anemia and/or thrombocytopenia; symptomatic or progressive lymphadenopathy, splenomegaly, or hepatomegaly; worsening disease-related symptoms (e.g. weight loss, fatigue, fever, night sweats); progressive lymphocytosis); **AND**
    - ❑ ECOG performance status between 0-2; **AND**
    - ❑ Life expectancy of ≥ 12 months; **AND**
    - ❑ Adequate hematologic function; **AND**
    - ❑ Adequate hepatic and renal function

AND

- ❑ Prescribed by an oncologist or qualified physician who is experienced in the use of anti-cancer agents

OR

- ❑ A diagnosis of relapsed or refractory mantle cell lymphoma (MCL) (443487006)
  - ❑ Have received at least one prior therapy

OR

- ❑ A diagnosis of Waldenström's macroglobulinemia (WM) (190818004)
  - ❑ Have received at least one prior therapy; **AND**
  - ❑ Measurable lymph node disease by CT scan; **AND**
  - ❑ ECOG performance status ≤1; **AND**
  - ❑ Patient is ≥18 years of age and older; **AND**

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Eligibility Criteria

- ❑ Physician is experienced in the use of anti-cancer agents (e.g. oncologist, hematologist, etc.); **AND**
- ❑ **None** of the following applies:
  - ❑ Prior malignancies
  - ❑ > 65 years of age in the presence of comorbidities that may place the patient at unacceptable risk of purine analog toxicity
  - ❑ Failure to respond, or a progression-free interval of <3 years from treatment with a purine analog based therapy and anti-CD20 containing chemo-immunotherapy regimen after at least 2 cycles
  - ❑ History of Richter's transformation or prolymphocytic leukemia
  - ❑ Contraindication to purine analogs

OR

❑ A diagnosis of Waldenström's macroglobulinemia (WM) (190818004)
- ❑ Will receive combination treatment with rituximab; **AND**
- ❑ Be ≥ 18 years of age; **AND**
- ❑ Measurable disease defined as serum monoclonal IgM >0.5 g/dL; **AND**
- ❑ Has symptomatic disease; **AND**
- ❑ Eastern Cooperative Oncology Group (ECOG) performance status of ≤2; **AND**
- ❑ Prescribed by an oncologist or qualified physician who is experienced in the use of anti-cancer agents

OR

❑ Diagnosis of chronic Graft vs. Host Disease (cGVHD) (402356004) after hematopoietic stem cell transplant (HSCT)
- ❑ Patient is 19-65 years of age, **AND**
- ❑ Meets <u>one</u> of the following criteria:
  - ❑ Steroid dependent disease, defined as when doses of prednisone >0.25mg/kg/day or >0.5mg/kg every other day are needed to prevent recurrence or progression of manifestations as demonstrated by attempts to taper the dose to lower levels on at least 2 occasions, separated by at least 8 weeks; **OR**
  - ❑ Refractory disease, defined as progressive disease, despite treatment with prednisone ≥ 0.5mg/kg per day for ≥ 4 weeks or progression despite the use of a regimen containing prednisone ≥1mg/kg/day for at least 1 week;

  AND
- ❑ Has at least <u>one</u> of the following:
  - ❑ >25% body surface area erythematous rash; **OR**
  - ❑ a NIH mouth score of >4

  AND
- ❑ Must have received ≤ 3 prior regimens for cGVHD in patients requiring prednisone ≥0.25mg/kg per day for ≥ 12 weeks; **AND**
- ❑ Must have failed one or more lines of systemic therapy

OR

❑ Diagnosis of marginal zone lymphoma (MZL) (447100004) who require systemic therapy, **AND**
- ❑ Have received at least one prior anti-CD20- based therapy, **AND**
- ❑ Patient is ≥18 years of age, **AND**
- ❑ ECOG performance status of ≤2,

OR

❑ None of the above applies

Relevant additional information _____

Physician Information			
Physician's Name	License Number	Telephone Number	Fax Number

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Eligibility Criteria			
Address	City	Province	Postal Code
Physician's Signature		Date: (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	