PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM
For Cancer therapy: *Venclexta (venetoclax)*

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 Patient

Employee or Insured's Name	Drug Card Number __ __ - __ __ __ __ __ __ - __ __ __ __ __ __ __ __ __ __ - __ __	
Patient's Name	Patient's Date of Birth (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	Relationship to Employee/Insured ❑Employee ❑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 am and 4 pm Eastern Time.

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

❑ E-mail	❑ Call me (and leave a message if I'm not there)	❑ 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
Venclexta (venetoclax)		

***Venclexta (venetoclax)* 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 the following criteria:

Criteria:

- ❑ For the treatment of chronic lymphocytic leukemia (CLL) (92814006);
  - ❑ Physician confirms the patient meets the drug's Health Canada approved indication; AND
  - ❑ The patient:
    - ❑ Is ≥18 years of age; AND
    - ❑ Has a diagnosis of Chronic lymphocytic leukemia (CLL) that requires treatment, according to International Workshop on Chronic Lymphocytic Leukemia (IWCLL) criteria; AND
    - ❑ Has an Eastern Cooperative Oncology Group (ECOG) Performance Status score ≤ 2; AND

      - ❑ Will use venetoclax as monotherapy; AND
      - ❑ Has disease that has relapsed after, or was refractory to, at least one prior CLL therapy (e.g. cyclophosphamide, fludarabine, rituximab);

      OR

      - ❑ Will use venetoclax in combination with Rituximab; AND
      - ❑ Has disease that has relapsed after, or was refractory to, at least one prior CLL therapy (e.g. cyclophosphamide, fludarabine);

      OR

      - ❑ Will use venetoclax in combination with Obinutuzumab; AND
      - ❑ Has previously untreated disease ; AND
      - ❑ Has a total Cumulative Illness Rating Scale [CIRS] score > 6 AND/OR a creatinine clearance [CrCL] < 70 mL/min; AND
      - ❑ Is ineligible for treatment with a fludarabine containing chemotherapy regimen; AND

      OR

      - ❑ Will use venetoclax in combination with ibrutinib; AND
      - ❑ Has previously untreated disease; AND
      - ❑ Has a confirmed diagnosis of CLL according to the National Cancer Institute (NCI)/International Workshop on Chronic Lymphocytic Leukemia (IWCLL) criteria; AND
      - ❑ Is ≥ 65 years of age; OR
        - ❑ Is <65 years of age; AND
          - ❑ Has a total Cumulative Illness Rating Scale [CIRS] score > 6; OR
          - ❑ Creatinine clearance [CrCl] estimated less than (<) 70 milliliter per minute (mL/min); AND
      - ❑ ECOG performance status between 0-2; AND
      - ❑ Measurable nodal disease by computed tomography (CT), defined as at least 1 lymph node >1.5 cm in the longest diameter; AND
      - ❑ Will use venetoclax as a regimen with a fixed duration of treatment in combination with ibrutinib (starting at cycle 4) for 12 cycles AND;

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Eligibility Criteria

- ❑ The prescriber is an oncologist or other specialist in the treatment of chronic lymphocytic leukemia (CLL)

OR

- ❑ For the treatment of newly diagnosed acute myeloid leukemia (AML) (91861009);
  - ❑ The patient:
    - ❑ Will use venetoclax in combination with azacitidine or low-dose cytarabine; AND
      - ❑ Is ≥ 75 years of age; AND
      - ❑ Has an Eastern Cooperative Oncology Group (ECOG) Performance Status score ≤ 2;

      OR
    - ❑ Is 18 to 74 years of age; AND
      - ❑ Has comorbidities that preclude the use of intensive induction chemotherapy; AND
      - ❑ Has an Eastern Cooperative Oncology Group (ECOG) Performance Status score ≤ 3; AND
  - ❑ The prescriber is an oncologist or other specialist in the treatment of acute myeloid leukemia (AML)

If prior authorization is approved, one Starter Kit may be authorized for the initial 4 week ramp-up dosing schedule (maximum of 4 weeks/42 tablets). The maximum does not apply for other package formats/strengths used for ongoing therapy.

OR

- ❑ None of the above applies

Relevant additional information _____

Physician Information

Physician's Name	License Number	Telephone Number	Fax Number	
Address		City	Province	Postal Code
Physician's Signature			Date: (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	