Prescriber Criteria Form

Brukinsa 2025 PA Fax 3414-A v4 010125.docx
Brukinsa (zanubrutinib)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Brukinsa (zanubrutinib).

Drug Name:
Brukinsa (zanubrutinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of mantle cell lymphoma (MCL)? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Has the patient received at least one prior therapy for mantle cell lymphoma? [If yes, then skip to question 7.] [If no, then no further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of Waldenstrom's macroglobulinemia (WM)? [If yes, then no further questions.]	Yes ◯	No ◯
4	Does the patient have a diagnosis of marginal zone lymphoma (MZL)? [If no, then skip to question 6.]	Yes ◯	No ◯
5	Has the patient received at least one anti-CD20-based regimen? [No further questions.]	Yes ◯	No ◯
6	Does the patient have a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL)? [If no, then skip to question 8.]	Yes ◯	No ◯

7	Has the patient experienced an intolerable adverse event, or does the patient have a contraindication to Calquence (acalabrutinib)? [No further questions.]	Yes ◯	No ◯
8	Does the patient have a diagnosis of follicular lymphoma? [If no, then no further questions.]	Yes ◯	No ◯
9	Has the patient received two or more lines of systemic therapy?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____