Prescriber Criteria Form

Calquence 2025 PA Fax 2398-A v2 010125.docx
Calquence (acalabrutinib)
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 Calquence (acalabrutinib).

Drug Name:
Calquence (acalabrutinib)

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 (MCL)? [No further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL)? [If yes, then no further questions.]	Yes ◯	No ◯
4	Does the patient have a diagnosis of Waldenstrom macroglobulinemia (lymphoplasmacytic lymphoma)? [If yes, then no further questions.]	Yes ◯	No ◯
5	Does the patient have a diagnosis of any of the following: A) extranodal marginal zone lymphoma of the stomach, B) extranodal marginal zone lymphoma of nongastric sites, C) nodal marginal zone lymphoma, D) splenic marginal zone lymphoma? [If no, then no further questions.]	Yes ◯	No ◯
6	Is the requested drug being used for the treatment of relapsed, refractory, or progressive disease?	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:_____