Prescriber Criteria Form Venclexta 2025 PA Fax 1353-A v1 010125.docx Venclexta (venetoclax) 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 Venclexta (venetoclax).

Drug Name: Venclexta (venetoclax)

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 chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL)? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of mantle cell lymphoma? [If yes, then no further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of acute myeloid leukemia (AML)? [If no, then skip to question 9.]	Yes ◯	No ◯
4	Does the patient have relapsed or refractory acute myeloid leukemia (AML)? [If yes, then no further questions.]	Yes ◯	No ◯
5	Does the patient have poor/adverse risk disease and is a candidate for intensive induction therapy? [If yes, then no further questions.]	Yes ◯	No ◯
6	Does the patient have newly-diagnosed acute myeloid leukemia (AML?) [If no, then no further questions.]	Yes ◯	No ◯
7	Is the patient 75 years of age or older? [If yes, then no further questions.]	Yes ◯	No ◯

8	Does the patient have comorbidities that preclude the use of intensive induction chemotherapy? [No further questions.]	Yes ◯	No ◯
9	Does the patient have a diagnosis of blastic plasmacytoid dendritic cell neoplasm (BPDCN)? [If no, then skip to question 12.]	Yes ◯	No ◯
10	Does the patient have systemic disease which is being treated with palliative intent? [If yes, then no further questions.]	Yes ◯	No ◯
11	Does the patient have relapsed or refractory disease? [No further questions.]	Yes ◯	No ◯
12	Does the patient have a diagnosis of multiple myeloma? [If no, then skip to question 16.]	Yes ◯	No ◯
13	Is the disease relapsed or progressive? [If no, then no further questions.]	Yes ◯	No ◯
14	Will the requested drug be used in combination with dexamethasone? [If no, then no further questions.]	Yes ◯	No ◯
15	Does the patient have a t(11:14) translocation? [No further questions.]	Yes ◯	No ◯
16	Does the patient have a diagnosis of Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma? [If no, then skip to question 19.]	Yes ◯	No ◯
17	Does the patient have previously treated disease that did not respond to primary therapy? [If yes, then no further questions.]	Yes ◯	No ◯
18	Does the patient have progressive or relapsed disease? [No further questions.]	Yes ◯	No ◯
19	Does the patient have a diagnosis of systemic light chain amyloidosis? [If no, then skip to question 21.]	Yes ◯	No ◯
20	Does the patient have relapsed or refractory disease with a t(11:14) translocation? [No further questions.]	Yes ◯	No ◯
21	Does the patient have a diagnosis of accelerated or blast phase myeloproliferative neoplasms? [If yes, then no further questions.]	Yes ◯	No ◯
22	Does the patient have a diagnosis of one of the following: A) B-cell acute lymphoblastic leukemia (B-ALL), B) T-cell acute lymphoblastic leukemia (T-ALL)? [If yes, then no further questions.]	Yes ◯	No ◯
23	Does the patient have a diagnosis of hairy cell leukemia?	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:_____