OKLAHOMA Health Care Authority

# State of Oklahoma SoonerCare
# Jaypirca™ (Pirtobrutinib) Prior Authorization Form

SoonerSelect | aetna

***Member Name:***_____ ***Date of Birth:***_____ ***Member ID#:***_____

## Drug Information

***Pharmacy Billing (NDC:***_____***) Start Date (or date of next dose):***_____

***Dose:***_____ ***Regimen:***_____

## Billing Provider Information

***Pharmacy NPI:***_____ ***Pharmacy Name:***_____

***Pharmacy Phone:***_____ ***Pharmacy Fax:***_____

## Prescriber Information

***Prescriber NPI:***_____ ***Prescriber Name:***_____

***Prescriber Phone:***_____ ***Prescriber Fax:***_____ ***Specialty:***_____

## Criteria

**For Initial Authorization:**

1. **Please indicate the diagnosis and information:**
   - ☐ **Chronic Lymphocytic/Small Lymphocytic Lymphoma (CLL/SLL)**
     - A. Has member received ≥2 lines of systemic therapy, including a Bruton's kinase (BTK) inhibitor and a BCL-2 inhibitor? Yes☐ No☐
   - ☐ **Mantle Cell Lymphoma (MCL)**
     - A. Does member have relapsed or refractory disease after ≥2 lines of systemic therapy? Yes☐ No☐
     - B. Does member's previous treatment include a Bruton's tyrosine kinase (BTK) inhibitor (e.g., acalabrutinib, ibrutinib, zanubrutinib)? Yes☐ No☐
   - ☐ **If diagnosis is not listed above, please indicate diagnosis:**_____

Additional Information:_____

_____

**For Continued Authorization:**

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on pirtobrutinib? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to pirtobrutinib therapy? Yes☐ No☐

*If yes, please specify adverse reactions:*_____

_____

**Prescriber Signature:**_____ **Date:**_____

***I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.*** *Failure to complete this form in full will result in processing delays.*

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**

CONFIDENTIALITY NOTICE

*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

DRAFT