

Prescriber Criteria Form

Brukinsta 2026 PA Fax 3414-A v2 010126.docx

Brukinsta (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 4.]	Yes	No
2	Is the requested drug being used for induction therapy? [If yes, then no further questions.]	Yes	No
3	Has the patient received at least one prior therapy for mantle cell lymphoma? [If yes, then skip to question 8.]	Yes	No
4	Does the patient have a diagnosis of Waldenstrom's macroglobulinemia (WM)? [If yes, then no further questions.]	Yes	No
5	Does the patient have a diagnosis of marginal zone lymphoma (MZL)? [If no, then skip to question 7.]	Yes	No
6	Has the patient received at least one anti-CD20-based regimen? [No further questions.]	Yes	No
7	Does the patient have a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL)? [If no, then skip to question 9.]	Yes	No

8	Has the patient experienced an intolerable adverse event or has a contraindication to Calquence (acalabrutinib)? [If yes, then no further questions.]	Yes	No
9	Does the patient have a diagnosis of follicular lymphoma? [If no, then skip to question 11.]	Yes	No
10	Has the patient received two or more lines of systemic therapy? [No further questions.]	Yes	No
11	Does the patient have a diagnosis of hairy cell leukemia? [If no, then no further questions.]	Yes	No
12	Is the disease relapsed or refractory?	Yes	No

Comments:	_____
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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: _____
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