Prescriber Criteria Form

Jaypirca 2026 PA Fax 5769-A v1 010126.docx
Jaypirca (pirtobrutinib)
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 Jaypirca (pirtobrutinib).

Drug Name:
Jaypirca (pirtobrutinib)

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	Does the patient have relapsed or refractory disease? [If no, then no further questions.]	Yes	No
3	Has the patient had at least two lines of systemic therapy, including a Bruton Tyrosine Kinase (BTK) inhibitor, for example, Calquence (acalabrutinib)? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL)? [If no, then skip the question 7.]	Yes	No
5	Has the patient received prior treatment with a Bruton Tyrosine Kinase (BTK) inhibitor, for example, Calquence (acalabrutinib)? [If no, then no further questions.]	Yes	No
6	Has the patient received prior treatment with a B-cell lymphoma 2 (BCL-2) inhibitor? [No further questions.]	Yes	No
7	Does the patient have a diagnosis of marginal zone lymphoma (MZL)? [If no, then no further questions.]	Yes	No

8	Has the patient received a covalent Bruton Tyrosine Kinase (BTK) inhibitor, for example, Calquence (acalabrutinib)?	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:**_____