Prescriber Criteria Form

Venclexta 2026 PA Fax 1353-A v1 010126.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 10.]	Yes	No
4	Does the patient have relapsed or refractory acute myeloid leukemia (AML)? [If yes, then no further questions.]	Yes	No
5	Will the requested drug be used as induction or consolidation therapy in patients with poor-risk or therapy related acute myeloid leukemia (AML)? [If yes, then no further questions.]	Yes	No
6	Will the requested drug be used for post-induction therapy following response to previous lower intensity therapy with the same regimen? [If yes, then no further questions.]	Yes	No
7	Does the patient have newly diagnosed acute myeloid leukemia (AML)? [If no, then no further questions.]	Yes	No

8	Is the patient 75 years of age or older? [If yes, then no further questions.]	Yes	No
9	Does the patient decline or have comorbidities that preclude the use of intensive induction chemotherapy? [No further questions.]	Yes	No
10	Does the patient have a diagnosis of blastic plasmacytoid dendritic cell neoplasm (BPDCN)? [If no, then skip to question 13.]	Yes	No
11	Does the patient have systemic disease which is being treated with palliative intent? [If yes, then no further questions.]	Yes	No
12	Does the patient have relapsed or refractory disease? [No further questions.]	Yes	No
13	Does the patient have a diagnosis of multiple myeloma? [If no, then skip to question 17.]	Yes	No
14	Is the disease relapsed or progressive? [If no, then no further questions.]	Yes	No
15	Will the requested drug be used in combination with one of the following: a) dexamethasone, b) dexamethasone and daratumumab, c) dexamethasone with bortezomib, carfilzomib, or ixazomib? [If no, then no further questions.]	Yes	No
16	Does the patient have a t(11:14) translocation? [No further questions.]	Yes	No
17	Does the patient have a diagnosis of Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma? [If no, then skip to question 20.]	Yes	No
18	Does the patient have previously treated disease that did not respond to primary therapy? [If yes, then no further questions.]	Yes	No
19	Does the patient have progressive or relapsed disease? [No further questions.]	Yes	No
20	Does the patient have a diagnosis of systemic light chain amyloidosis? [If no, then skip to question 22.]	Yes	No
21	Does the patient have relapsed or refractory disease with a t(11:14) translocation? [No further questions.]	Yes	No
22	Does the patient have a diagnosis of accelerated or blast phase myeloproliferative neoplasms? [If yes, then no further questions.]	Yes	No

23	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
24	Does the patient have a diagnosis of hairy cell leukemia? [If yes, then no further questions.]	Yes	No
25	Does the patient have a diagnosis of myelodysplastic syndrome that is higher risk? [If yes, then no further questions.]	Yes	No
26	Does the patient have a diagnosis of Chronic Myelomonocytic Leukemia (CMML)-2?	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:**_____