

CARTA CIRCULAR #M1507097

23 de julio de 2015

A TODOS LOS HEMATÓLOGOS-ONCÓLOGOS PARTICIPANTES DE TRIPLE-S SALUD
POLÍTICA DE PAGO DEL MEDICAMENTO IMBRUVICA® (IBRUTINIB)

Esta carta sustituye la carta circular #M1501005 del 30 de diciembre de 2014. Triple-S cubrirá el medicamento Imbruvica® (Ibrutinib) para aquellos asegurados cuya cubierta de farmacia incluya este medicamento. La política establecida en esta carta circular aplicará a los pacientes que utilicen Imbruvica® (Ibrutinib) a partir de la fecha de emisión de esta carta circular.

Se requiere documentar en la receta los siguientes criterios. También se adjunta la hoja de pre-certificación para completar el proceso de evaluación.

A) RECETA EMITIDA POR:

- Hematólogo/Oncólogo

B) DIAGNÓSTICO:

- Linfoma de células del manto en paciente que han recibido al menos una terapia previa (ICD9 200.40 ó ICD10-CM C83.10)
- Leucemia linfocítica crónica (CLL) en paciente que han recibido al menos una terapia previa (ICD9 204.12 o ICD 10-CM C91.12)
- Leucemia linfocítica crónica (CLL) con la remoción del 17p (ICD9 204.12 o ICD 10-CM C91.12)
- Waldenström's macroglobulinemia (WM) (ICD9 273.3 ICD10-CM C88.0)

C) DOCUMENTAR:

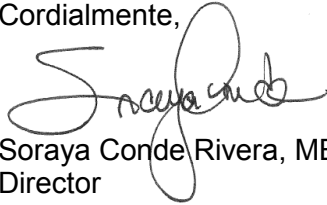
- Tratamiento previo con al menos un agente indicado para el tratamiento de linfoma de células del manto y leucemia linfocítica crónica (CLL) en pacientes sin la remoción del 17p

IMPORTANTE este cambio **no** aplica a:

- Programas de Triple-S Advantage
- Algunos planes comerciales.
- Asegurados del Plan de Salud de Gobierno de Puerto Rico

Si necesita información adicional, comuníquese con nuestro Departamento de Gerencia de Servicio al 787-749-4700 o al 1-877-357-9777 (para llamadas de larga distancia, libre de cargos).

Cordialmente,



Soraya Conde Rivera, MBA, R.Ph
Director
Departamento de Farmacia
Unidad de Gerencia Clínica



Ángela T. Hernández Michels, MD
Director Médico Asociado
División de Asuntos Médicos y Dentales



Request Form for Imbruvica® (Ibrutinib)
Pharmacy Department 787-774-4832 (Fax)

Physician Information

Name:
License: Physician specialty:
Address:
Telephone: Fax:

Patient General Information

Name: Member ID:
Date of birth: Address:
Sex: M F Weight:

Medication requested:

Imbruvica® (Ibrutinib) Dose: Sig:

Medical Information

Please answer the following questions:

- 1) The patient presents the following diagnosis:
Mantle Cell Lymphoma (ICD9 200.40 OR ICD10-CM C83.10)
Chronic lymphocytic leukemia (CLL) (ICD9 204.12 ó ICD10-CM C91.12)
Chronic lymphocytic leukemia with 17p deletion (ICD9 204.12 ó ICD10-CM C91.1)
Waldenström's macroglobulinemia (WM) (ICD9 273.3 ICD10-CM C88.0)
Other (Please specify):

- 2) The patient presents 17 p deletion?
Yes No
3) The patient has received at least one prior therapy?
Yes No

If yes please document previous therapy:

Please provide any medical information which may support approval: (optional)

Physician signature:

Date:

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