CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Blincyto® – Prior Authorization Request

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 866-249-6155

CVS/caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS/caremark toll-free at 866-249-6155**. If you have questions regarding the prior authorization, please contact CVS/caremark at **866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 800-237-2767.

Patient Name:	**Date**:
Patient's ID:	**Patient's Date of Birth:**
Physician's Name:	
Specialty:	**NPI#:**
Physician Office Telephone:	**Physician Office Fax:**

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

1. Which drug is being requested? ☐ Blinctyo® ☐ Other _____________________
2. What is the diagnosis?
   ☐ Acute lymphoblastic leukemia (ALL) ☐ Other ____
3. What is the ICD code? _____________
4. Does the patient have B-cell precursor ALL? ☐ Yes ☐ No ☐ Unknown
5. Prior to initiation of therapy, has flow cytometry been performed to identify the CD19 protein on the surface of the B-cell?
   Action Required*: *Attach laboratory documentation. ☐ Yes ☐ No
6. Prior to initiation of therapy, were the cancer cells CD19 positive? ☐ Yes ☐ No
7. What is the Philadelphia chromosome status of the leukemia?
   ☐ Philadelphia chromosome-negative ALL ☐ Philadelphia chromosome-positive ALL ☐ Unknown
8. Prior to initiation of therapy, was the diagnosis of Ph-negative ALL confirmed by any of the following?
   Action Required*: *Attach laboratory documentation.
   ☐ Cytogenetic (conventional or FISH) testing
   ☐ Molecular (PCR) testing
   ☐ Other ____
   ☐ Not applicable
9. Prior to initiation of therapy, were the cancer cells Ph-negative and/or BCR-ABL negative? ☐ Yes ☐ No
10. Does the patient have relapsed or refractory disease? ☐ Yes ☐ No
11. How many months of Blincyto® therapy has the patient received in their LIFETIME? _____________ months

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS/caremark or the benefit plan sponsor.

X____

Prescriber or Authorized Signature **Date: (mm/dd/yy)**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Blincyto SGM – 1/2015