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Prior Authorization Request

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 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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

1. What is the patient's diagnosis?
   - ❑ Chronic myeloid leukemia (CML)
   - ❑ Acute lymphoblastic leukemia (ALL)/lymphoblastic lymphoma (LL)
   - ❑ Myeloid neoplasm with eosinophilia
   - ❑ Lymphoid neoplasm with eosinophilia
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the patient currently receiving treatment with the requested medication?
   ❑ Yes ❑ No *If No, skip to #5*
4. Is there evidence of unacceptable toxicity or disease progression on the current regimen? ❑ Yes ❑ No
   If diagnosis is myeloid or lymphoid neoplasm with eosinophilia, no further questions
5. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR-ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ***ACTION REQUIRED: If Yes, attach results of cytogenetic and/or molecular testing (not required if request is for continuation of treatment).*** ❑ Yes ❑ No
6. Has the patient received prior therapy with another tyrosine kinase inhibitor (TKI) (e.g., dasatinib [Sprycel®], imatinib [Gleevec®], nilotinib [Tasigna®], ponatinib [Iclusig®])? ❑ Yes ❑ No *If No, skip to diagnosis section*
7. Which of the following has the patient experienced while receiving prior therapy with another TKI?
   If Toxicity or Intolerance, skip to diagnosis section
   - ❑ Toxicity
   - ❑ Intolerance
   - ❑ Resistance
   - ❑ None of the above
8. Was the BCR-ABL1 mutational test result negative for all of the following mutations: T315I, G250E, V299L, and F317L? ***ACTION REQUIRED: Attach BCR-ABL1 mutation test result for T315I, G250E, V299L, and F317L mutations.*** ❑ Yes ❑ No ❑ Unknown or testing has not been completed

Complete the following section based on the patient's diagnosis, if applicable.

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155

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Section A: Acute Lymphoblastic Leukemia (ALL)/Lymphoblastic Lymphoma (LL)

9. Has the patient received a hematopoietic stem cell transplant (HSCT) for acute lymphoblastic leukemia (ALL)? ❑ Yes ❑ No

Section B: Chronic Myeloid Leukemia (CML)

10. Has the patient received a hematopoietic stem cell transplant (HSCT) for chronic myeloid leukemia (CML)? ❑ Yes ❑ No

11. *If the patient is currently receiving treatment with the requested medication*, how many months of treatment with the requested medication has the patient received? _____ months
If greater than 12 months, no further questions

12. What is the most recent BCR-ABL1 (IS) level? _____ % ❑ Unknown

Section C: Myeloid/Lymphoid Neoplasm with Eosinophilia

13. Does the disease have ABL1 rearrangement? ***ACTION REQUIRED: If Yes, attach results of testing or analysis confirming ABL1 rearrangement.*** ❑ Yes ❑ No ❑ Unknown or testing has not been completed

14. Is the disease in the chronic phase or blast phase?
❑ Yes, chronic phase ❑ Yes, blast phase ❑ None of the above

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*

4. Is the alternate drug (prednisone) FDA-approved for the medical condition being treated?
❑ Yes ❑ No *If No, no further questions.*

5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*

6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*

7. Are any of the following conditions met for the alternate drug (prednisone)?
If Yes, indicate below and no further questions.
❑ The alternate drug is contraindicated
❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
❑ The alternate drug is expected to be ineffective
❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
❑ The alternate drug is not in the patient's best interest
❑ The alternate drug was tried while covered by the current or the previous health benefit plan
❑ None of the above, *continue to #8*

8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ Yes ❑ No

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)**

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