CVS caremark™ {{PANUMCODE}}

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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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis?
   - ❑ Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
   - ❑ T-Cell lymphomas
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #5*
4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions.*
5. Will the requested medication be used as a single agent? ❑ Yes ❑ No

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

Section A: Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)

6. Is the patient's disease relapsed or refractory? ❑ Yes ❑ No

Section B: T-Cell Lymphomas

7. Will the requested medication be used to treat one of the following subtypes?
   - ❑ Breast implant-associated anaplastic large cell lymphoma (ALCL), *skip to #9*
   - ❑ Hepatosplenic T-Cell lymphoma
   - ❑ Peripheral T-cell lymphoma (PTCL) [including the following subtypes: peripheral T-cell lymphoma not otherwise specified, enteropathy-associated T-cell lymphoma (EATL), monomorphic epitheliotropic intestinal T-cell lymphoma (MEITL), angioimmunoblastic T-cell lymphoma (AITL), nodal peripheral T-cell lymphoma with TFH phenotype (PTCL, TFH), follicular T-cell lymphoma, or anaplastic large cell lymphoma (ALCL)], *skip to #11*
   - ❑ Other _____
8. Will the requested medication be used for refractory disease after 2 first-line regimens?
   ❑ Yes ❑ No *No further questions.*

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

9. *For breast implant-associated ALCL*, what is the place in therapy in which the requested medication be used?
   - ❑ First line therapy
   - ❑ Subsequent therapy

10. *For breast implant-associated ALCL,* what is the clinical setting in which the requested medication will be used?
    - ❑ Relapsed disease
    - ❑ Refractory disease
    - ❑ Other _____ *No further questions.*

11. What is the place in therapy in which the requested medication be used?
    - ❑ Palliative therapy
    - ❑ Subsequent therapy
    - ❑ Other _____

12. What is the clinical setting in which the requested medication will be used?
    - ❑ Relapsed disease
    - ❑ Refractory disease
    - ❑ Other _____

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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