Folotyn

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.

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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?
   - ❑ Peripheral T-cell lymphoma (PTCL)
   - ❑ Adult T-cell leukemia/lymphoma (ATLL)
   - ❑ Mycosis fungoides (MF)
   - ❑ Cutaneous anaplastic large cell lymphoma (ALCL)
   - ❑ Extranodal NK/T-cell lymphoma, nasal type
   - ❑ Hepatosplenic gamma-delta T-cell lymphoma
   - ❑ Sezary syndrome (SS)
   - ❑ Other ______________________________
2. What is the ICD-10 code? _____________
3. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #5*
4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions*
5. How will the requested drug be used? ***Indicate ALL that apply.***
   ❑ As a single agent ❑ As second-line or subsequent therapy ❑ None of the above

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

Section A: Peripheral T-Cell Lymphoma (PTCL) or Extranodal NK/T-Cell Lymphoma (Nasal Type)

6. Is the disease relapsed or refractory? ❑ Yes ❑ No *If diagnosis is PTCL, no further questions.*
7. Has the patient had an inadequate response to asparaginase-based therapy (e.g., pegaspargase)?
   If Yes, no further questions. ❑ Yes ❑ No
8. Does the patient have a contraindication to asparaginase-based therapy (e.g., pegaspargase)? ❑ Yes ❑ No

Section B: Hepatosplenic Gamma-Delta T-Cell Lymphoma

9. How many previous lines of chemotherapy has the patient received? ____________ lines

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)**

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

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CVS Caremark Prior Authorization ● 1300 E. Campbell Road ● Richardson, TX 75081
Phone: 1-866-814-5506 ● Fax: 1-866-249-6155 ● www.caremark.com