Gazyva

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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

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

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ AIDS-related B-cell lymphoma
   - ❑ Burkitt lymphoma
   - ❑ Castleman's disease
   - ❑ Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL)
   - ❑ Diffuse large B-cell lymphoma
   - ❑ Follicular lymphoma (FL)
   - ❑ Gastric MALT lymphoma
   - ❑ High-grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified)
   - ❑ Histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma
   - ❑ Mantle cell lymphoma (MCL)
   - ❑ Nodal marginal zone lymphoma
   - ❑ Non-gastric MALT lymphoma
   - ❑ Post-transplant lymphoproliferative disorder
   - ❑ Splenic marginal zone lymphoma
   - ❑ 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 diagnosis section.*
4. Has the patient experienced disease progression or unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No
5. *For follicular lymphoma (FL) only,* how many months of therapy with the requested medication has the patient received in their current course of therapy? _____ months *No further questions*

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

Section A: Follicular Lymphoma (FL)

6. How will the requested medication be used?
   - ❑ The requested medication will be used as first line therapy, *skip to #8*
   - ❑ The requested medication will be used as subsequent therapy, *skip to #8*
   - ❑ The requested medication will be used as maintenance therapy, *skip to #8*
   - ❑ The requested medication will be used as a substitute for rituximab
   - ❑ Other _____
7. Has the patient experienced intolerance or rare complications from rituximab such as mucocutaneous reactions including paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis? Note: Re-challenge with the same anti-CD20 monoclonal antibody is not recommended and it is unclear if the use of an alternative anti-CD20 monoclonal antibody poses the same risk of recurrence. ❑ Yes ❑ No
8. Will the requested drug be used in combination with any of the following?
   - ❑ CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone)
   - ❑ CVP (cyclophosphamide, vincristine and prednisone)
   - ❑ Bendamustine
   - ❑ Lenalidomide
   - ❑ As a single agent
   - ❑ Other _____
9. How many months of therapy with the requested medication has the patient received in their current course of therapy? _____ months

Section B: Gastric MALT Lymphoma, Non-Gastric MALT Lymphoma, Nodal Marginal Zone Lymphoma, Splenic Marginal Zone Lymphoma

10. How will the requested medication be used?
    - ❑ The requested medication will be used as first-line therapy
    - ❑ The requested medication will be used as second-line or subsequent therapy in combination with bendamustine, *no further questions*
    - ❑ The requested medication will be used as maintenance therapy in a patient who has been treated with the requested medication and bendamustine, *no further questions*
    - ❑ The requested medication will be used as a substitute for rituximab, *skip to #12*
    - ❑ Other _____

11. Will the requested drug be used in combination with any of the following? *No further questions*
    - ❑ CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) regimen
    - ❑ CVP (cyclophosphamide, vincristine and prednisone) regimen
    - ❑ Bendamustine
    - ❑ Other _____

12. Has the patient experienced intolerance or rare complications from rituximab such as mucocutaneous reactions including paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis? Note: Re-challenge with the same anti-CD20 monoclonal antibody is not recommended and it is unclear if the use of an alternative anti-CD20 monoclonal antibody poses the same risk of recurrence. ❑ Yes ❑ No

Section C: Histologic Transformation of Marginal Zone Lymphoma to Diffuse Large B-Cell Lymphoma, Mantle Cell Lymphoma (MCL), Diffuse Large B-Cell Lymphoma, High-Grade B-Cell Lymphoma, Burkitt Lymphoma, AIDS-Related B-Cell Lymphoma, Post-Transplant Lymphoproliferative Disorder, Castleman's Disease

13. Will the requested medication be used as a substitute for rituximab? ❑ Yes ❑ No

14. Has the patient experienced intolerance or rare complications from rituximab such as mucocutaneous reactions including paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis? Note: Re-challenge with the same anti-CD20 monoclonal antibody is not recommended and it is unclear if the use of an alternative anti-CD20 monoclonal antibody poses the same risk of recurrence. ❑ Yes ❑ No

Section D: Chronic Lymphocytic Leukemia (CLL), Small Lymphocytic Lymphoma (SLL)

15. How will the requested medication be used?
    - ❑ The requested medication will be used as a single agent
    - ❑ The requested medication will be used in combination with acalabrutinib
    - ❑ The requested medication will be used in combination with venetoclax
    - ❑ The requested medication will be used in combination with bendamustine
    - ❑ The requested medication will be used in combination with chlorambucil
    - ❑ 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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