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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 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? _____
   If diagnosis is myeloid or lymphoid neoplasm with eosinophilia, skip to #4
3. 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 test results.*** ❑ Yes ❑ No
4. Is the patient currently receiving the requested medication? ❑ Yes ❑ No *If No, skip to diagnosis section*
5. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions*

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

Section A: Chronic Myeloid Leukemia (CML)

6. Does the patient have T315I-positive chronic myeloid leukemia (CML)? ***ACTION REQUIRED: If Yes, attach T315I mutation test results and no further questions.***
   ❑ Yes ❑ No ❑ Unknown or testing has not been completed
7. What phase is the patient's disease?
   - ❑ Chronic phase
   - ❑ Accelerated phase, *skip to #9*
   - ❑ Blast phase, *skip to #9*

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8. Has the patient experienced resistance or intolerance to at least two prior kinase inhibitors (e.g., imatinib [Gleevec®], nilotinib [Tasigna®], dasatinib [Sprycel®], bosutinib [Bosulif®])?
   ❑ Yes ❑ No *No further questions*

9. Is treatment with ANY other kinase inhibitor (e.g., bosutinib [Bosulif®]), dasatinib [Sprycel®], imatinib [Gleevec®], nilotinib [Tasigna®]) indicated for this patient? ❑ Yes ❑ No

Section B: Myeloid Neoplasm with Eosinophilia and Lymphoid Neoplasm with Eosinophilia

10. Does the disease have ABL1 or FGFR1 rearrangement? ***ACTION REQUIRED: If Yes, attach results of testing or analysis confirming ABL 1 or FGFR1 rearrangement.*** ❑ Yes ❑ No ❑ Unknown

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

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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