

Imbruvica
Prior Authorization Request

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

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

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 lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL)
 Mantle cell lymphoma (MCL)
 Waldenstrom's Macroglobulinemia/lymphoplasmacytic lymphoma
 Marginal zone lymphoma
 Other _____
2. What is the ICD-10 code? _____

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

Section A: Mantle Cell Lymphoma (MCL)

3. Has the patient received at least one prior therapy for MCL? Yes No
**Note: Examples of therapies for MCL include, but are not limited to, chemotherapy plus Rituxan, radiation therapy, Velcade, Revlimid and stem cell transplantation.*

Section B: Marginal Zone Lymphoma

4. Does the patient require systemic therapy? Yes No
5. Has the patient previously received an anti-CD20-based therapy (e.g., Rituxan)? 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)**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Imbruvica SGM - 3/2017.

CVS Caremark is an independent company that provides pharmacy benefit management services to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. members.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are both independent licensees of the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Names and Symbols are registered trademarks of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.