Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

CVS caremark™ {{PANUMCODE}}

Imbruvica

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: {{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 patient's diagnosis?
   - ❑ Mantle cell lymphoma (MCL)
   - ❑ Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL)
   - ❑ Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma
   - ❑ Marginal zone lymphoma (MZL) (such as gastric or non-gastric MALT lymphoma, nodal or splenic marginal zone lymphoma)
   - ❑ Chronic graft-versus-host disease (cGVHD)
   - ❑ Hairy cell leukemia
   - ❑ Primary central nervous system lymphoma
   - ❑ Follicular lymphoma
   - ❑ Histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma
   - ❑ Diffuse large B-cell 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)
   - ❑ AIDS-related B-cell lymphoma
   - ❑ Post-transplant lymphoproliferative disorders
   - ❑ Histologic transformation of follicular lymphoma to diffuse large B-cell 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 #5*
4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions.*
5. What is the requested regimen? *List continues on next page*.
   - ❑ The requested medication as a single agent
   - ❑ The requested medication in combination with rituximab
   - ❑ The requested medication in combination with obinutuzumab
   - ❑ The requested medication in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (rituximab, cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen

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

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❑ The requested medication in combination with high-dose methotrexate and rituximab
❑ Other _____

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

Section A: Mantle Cell Lymphoma (MCL)
6. Has the patient received at least one prior therapy for mantle cell lymphoma? ❑ Yes ❑ No

Section B: Marginal Zone Lymphoma (MZL)
7. Has the patient received at least one prior therapy for MZL? ❑ Yes ❑ No

Section C: Chronic Graft-Versus-Host Disease (cGVHD)
8. Has the patient failed at least one or more lines of therapy? ❑ Yes ❑ No

Section D: Hairy Cell Leukemia
9. Will the requested medication be used as a single agent for disease progression? ❑ Yes ❑ No

Section E: Primary Central Nervous System Lymphoma
10. Is the disease relapsed or refractory? *If Yes, no further questions* ❑ Yes ❑ No

11. Will the requested medication be used for induction therapy? ❑ Yes ❑ No

Section F: Histologic Transformation of Nodal Marginal Zone Lymphoma to Diffuse Large B-Cell Lymphoma
12. Has the patient received prior chemoimmunotherapy? ❑ Yes ❑ No

Section G: Diffuse Large B-Cell Lymphoma, Follicular 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)
13. Will the requested medication be used as second-line or subsequent therapy? ❑ Yes ❑ No

Section H: AIDS-Related B-Cell Lymphoma
14. Is the patient's disease relapsed? ❑ Yes ❑ No

15. Will the requested medication be used as second-line or subsequent therapy? ❑ Yes ❑ No

Section I: Post-Transplant Lymphoproliferative Disorders, Histologic Transformation of Follicular Lymphoma to Diffuse Large B-Cell Lymphom
16. Has the patient received prior chemoimmunotherapy? ❑ 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)**

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

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