CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Mitoxantrone® – Prior Authorization Request

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 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 866-249-6155**. If you have questions regarding the prior authorization, please contact CVS/caremark at **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® 800-237-2767.

Patient Name:	**Date**:
Patient's ID:	**Patient's Date of Birth:**
Physician's Name:	
Specialty:	**NPI#:**
Physician Office Telephone:	**Physician Office Fax:**

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

1. What drug is being prescribed? ☐ Mitoxantrone® ☐ Other _____

2. What is the patient's diagnosis?
   - ☐ Multiple sclerosis (MS)
   - ☐ Acute nonlymphocytic leukemia (this includes AML and APL)
   - ☐ Hodgkin's lymphoma
   - ☐ Prostate cancer
   - ☐ Non-Hodgkin lymphoma (NHL)
   - ☐ Breast cancer
   - ☐ Liver carcinoma
   - ☐ Ovarian cancer
   - ☐ Other _____

3. What is the ICD code? _____

4. *If the diagnosis is non-Hodgkin's lymphoma,* what is the subtype?
   - ☐ Adult T-cell leukemia/lymphoma
   - ☐ T-cell prolymphocytic leukemia
   - ☐ Follicular lymphoma
   - ☐ Gastric MALT lymphoma
   - ☐ Non-gastric MALT lymphoma
   - ☐ AIDS-related B-cell lymphoma
   - ☐ Diffuse large B-cell lymphoma
   - ☐ Splenic marginal zone lymphoma (MZL)
   - ☐ Peripheral T-cell lymphoma
   - ☐ Primary cutaneous B cell lymphoma
   - ☐ Mantle cell lymphoma
   - ☐ Mycosis fungoides or Sezary syndrome (types of cutaneous T cell lymphoma)
   - ☐ 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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