

**Oncaspar  
Prior Authorization Request**

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

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 **1-866-814-5506**. 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:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_

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

**Additional Demographic Information:**

*Patient Weight:* \_\_\_\_\_ kg  
*Patient Height:* \_\_\_\_\_ ft \_\_\_\_\_ inches

*Please indicate the place of service for the requested drug:*

- Ambulatory Surgical  Home  Inpatient Hospital  Off Campus Outpatient Hospital  
 On Campus Outpatient Hospital  Office  Pharmacy

**Criteria Questions:**

- What is the diagnosis?  
 Acute lymphoblastic leukemia (ALL)  
 Lymphoblastic lymphoma  
 Extranodal natural killer/T-cell lymphoma, nasal type  
 Other \_\_\_\_\_
- What is the ICD-10 code? \_\_\_\_\_
- Will Oncaspar be used in conjunction with multi-agent chemotherapy?  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)**

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