Polivy

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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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:** ___________________

<u>Referring</u> Provider Info: ❑ Same as Requesting Provider
Name: ______________________________________ **NPI#:** ______________________________
Fax: ________________________ **Phone:** _____________________

<u>Rendering</u> Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: ______________________________________ **NPI#:** ______________________________
Fax: ________________________ **Phone:** _____________________

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

<u>Required Demographic Information:</u>

Patient Weight: _________________________*kg*

*Patient Height:*_________________________*cm*

Please indicate the place of service for the requested drug:
❑ Ambulatory Surgical *❑ Home* *❑ Off Campus Outpatient Hospital*
❑ On Campus Outpatient Hospital *❑ Office* *❑ Pharmacy*

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

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. Polivy SGM – 04/2021.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Clinical Criteria Questions:

1. What is the diagnosis?
   ❑ Diffuse large B-cell lymphoma
   ❑ High grade B-cell lymphomas (HGBLs) (also referred to as "double-hit" or "triple-hit" lymphomas
   ❑ Mantle cell lymphoma
   ❑ Monomorphic post-transplant lymphoproliferative disorders (B-cell type)
   ❑ Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphomas (AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, AIDS-related plasmablastic lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma)
   ❑ Histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma
   ❑ Histologic transformation of follicular lymphoma to diffuse large B-cell lymphoma without translocations of MYC and BCL2 and/or BCL6
   ❑ Follicular lymphoma
   ❑ Other ____________________________

2. What is the ICD-10 code? _____________

3. Is the patient currently receiving treatment with the requested drug? ❑ Yes ❑ No *If No, skip to #6*

4. How many cycles of the requested drug has the patient received in a lifetime? _____________ cycles

5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions.*

6. What is the regimen request?
   ❑ The requested drug will be used as a single agent
   ❑ The requested drug will be used in combination with bendamustine only
   ❑ The requested drug will be used in combination with bendamustine and rituximab
   ❑ Other

7. How many cycles of chemotherapy containing the requested drug are planned? _____________ cycles

8. What is the place in therapy the requested drug will be used? ❑ First-line treatment ❑ Subsequent treatment

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

Section A: Diffuse large B-cell lymphoma, High-grade B-cell lymphoma

9. Is the patient a candidate for transplant? ❑ Yes ❑ No

Section B: Mantle cell lymphoma

10. Has the member received at least two prior therapies? ❑ Yes ❑ No

Section C: Monomorphic post-transplant lymphoproliferative disorders (B-cell type), histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma

11. Has the member received at least two prior chemoimmunotherapies? ❑ 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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