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:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering 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.

Required Demographic Information:

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*

Clinical Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Diffuse large B-cell lymphoma (DLBCL), *Continue to 2*
❒ High-grade B-cell lymphomas (HGBLs) (also referred to as "double-hit" or "triple-hit" lymphomas), *Continue to 2*
❒ Monomorphic post-transplant lymphoproliferative disorders (B-cell type), *Continue to 2*
❒ 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), *Continue to 2*

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❒ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma (DLBCL), *Continue to 2*

❒ Follicular lymphoma, *Continue to 2*

❒ Other, please specify. _____ *Continue to 2*

2. Is the patient currently receiving treatment with the requested drug?

❒ Yes, *Continue to 3*
❒ No, *Continue to 5*

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

please indicate number of cycles: _____ cycles, *Continue to 4*

4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

5. What is the diagnosis?

❒ Diffuse large B-cell lymphoma (DLBCL), *Continue to 6*
❒ High-grade B-cell lymphomas (HGBLs) (also referred to as "double-hit" or "triple-hit" lymphomas), *Continue to 14*

❒ Monomorphic post-transplant lymphoproliferative disorders (B-cell type), *Continue to 22*
❒ 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), *Continue to 22*

❒ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma (DLBCL), *Continue to 27*
❒ Follicular lymphoma, *Continue to 31*

6. Will the requested drug be used for previously untreated intermediate-risk or high-risk diffuse large B-cell lymphoma (DLBCL)?

❒ Yes, *Continue to 7*
❒ No, *Continue to 9*

7. Will the requested drug be used in combination with chemotherapy?

❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

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

❒ More than 6, *No Further Questions*

❒ 6 or less, *No Further Questions*

9. What is the regimen request?

❒ The requested drug will be used as a single agent, *Continue to 10*

❒ The requested drug will be used in combination with bendamustine, *Continue to 10*

❒ The requested drug will be used in combination with bendamustine and rituximab, *Continue to 10*

❒ Other, please specify. _____, *Continue to 10*

10. What is the place in therapy the requested drug will be used?

❒ First-line treatment, *Continue to 11*

❒ Subsequent treatment, *Continue to 11*

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

❒ More than 6, *Continue to 12*

❒ 6 or less, *Continue to 12*

12. Will the requested medication be used as a bridging option until CAR T-cell product is available?

❒ Yes, *No Further Questions*

❒ No, *Continue to 13*

13. Is the patient a candidate for transplant?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

14. What is the regimen request?

❒ The requested drug will be used as a single agent, *Continue to 15*

❒ The requested drug will be used in combination with bendamustine, *Continue to 15*

❒ The requested drug will be used in combination with bendamustine and rituximab, *Continue to 15*

❒ The requested drug will be used in combination with a rituximab product, cyclophosphamide, doxorubicin, and prednisone (R-CHP), *Continue to 19*

❒ Other, please specify. _____, *No Further Questions*

15. What is the place in therapy the requested drug will be used?

❒ First-line treatment, *Continue to 16*

❒ Subsequent treatment, *Continue to 16*

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

❒ More than 6, *Continue to 17*

❒ 6 or less, *Continue to 17*

17. Will the requested medication be used as a bridging option until CAR T-cell product is available?

❒ Yes, *No Further Questions*

❒ No, *Continue to 18*

18. Is the patient a candidate for transplant?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

19. What is the place in therapy the requested drug will be used?

❒ First-line treatment, *Continue to 20*

❒ Subsequent treatment, *Continue to 20*

20. What is the International Prognostic Index score?

❒ 0-1, *Continue to 21*

❒ 2 or greater, *Continue to 21*

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

❒ More than 6, *No Further Questions*

❒ 6 or less, *No Further Questions*

22. What is the regimen request?

❒ The requested drug will be used in combination with bendamustine, *Continue to 23*

❒ The requested drug will be used as a single agent, *Continue to 23*

❒ The requested drug will be used in combination with bendamustine and rituximab, *Continue to 23*

❒ Other, please specify. _____, *Continue to 23*

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

❒ More than 6, *Continue to 24*

❒ Less than 6, *Continue to 24*

24. What is the place in therapy the requested drug will be used?

❒ First-line treatment, *Continue to 25*

❒ Subsequent treatment, *Continue to 25*

25. Will the requested medication be used as a bridging option until CAR T-cell product is available?

❒ Yes, *No Further Questions*

❒ No, *Continue to 26*

26. Is the patient a candidate for transplant?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

27. What is the regimen request?

❒ The requested drug will be used in combination with bendamustine, *Continue to 28*

❒ The requested drug will be used as a single agent, *Continue to 28*

❒ The requested drug will be used in combination with bendamustine and rituximab, *Continue to 28*

❒ Other, please specify. _____, *Continue to 28*

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

❒ More than 6, *Continue to 29*

❒ Less than 6, *Continue to 29*

29. What is the place in therapy the requested drug will be used?

❒ First-line treatment, *Continue to 30*

❒ Subsequent treatment, *Continue to 30*

30. Is the patient a candidate for transplant?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

31. What is the regimen request?

❒ The requested drug will be used in combination with bendamustine, *Continue to 32*

❒ The requested drug will be used as a single agent, *Continue to 32*

❒ The requested drug will be used in combination with bendamustine and rituximab, *Continue to 32*

❒ Other, please specify. _____, *Continue to 32*

32. What is the place in therapy the requested drug will be used?

❒ First-line treatment, *Continue to 33*

❒ Subsequent treatment, *Continue to 33*

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

❒ More than 6, *No Further Questions*

❒ Less than 6, *No Further Questions*

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 Specialty Programs Fax: 1-855-330-1720

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