



## Purixan

### 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:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_  
**Request Initiated For:** \_\_\_\_\_

1. What is the diagnosis?
  - Acute lymphoblastic leukemia (ALL)
  - Acute promyelocytic leukemia (APL)
  - Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. Is the patient currently receiving treatment with the requested medication?  Yes  No *If No, skip to #5*
4. Has the patient experienced disease progression or an unacceptable toxicity while receiving the requested drug/regimen?  Yes  No *No further questions*
5. Is the patient able to swallow the tablet formulation?  Yes  No *If No, no further questions.*
6. Has the patient had a documented intolerable adverse event with the generic alternative mercaptopurine (and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information)? **ACTION REQUIRED: If Yes, attach supporting chart note(s).**  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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**CVS Caremark Prior Authorization • 1300 E. Campbell Road • Richardson, TX 75081  
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