Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

{{PANUMCODE}}

Revlimid

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.

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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the patient's diagnosis?
   - ❑ Multiple myeloma
   - ❑ Non-Hodgkin lymphoma
   - ❑ Myelodysplastic syndrome
   - ❑ Myelofibrosis-associated anemia
   - ❑ Systemic light chain amyloidosis
   - ❑ Classical Hodgkin lymphoma
   - ❑ POEMS syndrome
   - ❑ Myelodysplastic syndrome/myeloproliferative neoplasms
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Is this a request for continuation of therapy with the requested drug?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*

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

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

Section A: Non-Hodgkin Lymphoma

5. Which of the following NHL subtypes does the patient have? *List continues on the next page.*
   - ❑ AIDS-related diffuse large B-cell lymphoma
   - ❑ Primary central nervous system (CNS) lymphoma
   - ❑ Post-transplant lymphoproliferative disorder (non-germinal center B-cell type)
   - ❑ Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
   - ❑ Histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma
   - ❑ Non-germinal center diffuse large B-cell lymphoma
   - ❑ Follicular lymphoma
   - ❑ Mantle cell lymphoma
   - ❑ Nongastric MALT lymphoma
   - ❑ Recurrent or progressive gastric MALT lymphoma

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- ❑ Primary cutaneous B-cell lymphoma
- ❑ Nodal marginal zone lymphoma
- ❑ Splenic marginal zone lymphoma
- ❑ Multicentric Castleman's disease
- ❑ Primary cutaneous anaplastic large cell lymphoma (ALCL) or cutaneous ALCL
- ❑ Adult T-cell leukemia/lymphoma (acute or lymphoma subtypes)
- ❑ Mycosis fungoides (MF)/Sezary syndrome (SS)
- ❑ Angioimmunoblastic T-cell lymphoma (AITL)
- ❑ Peripheral T-cell lymphoma not otherwise specified (PTCL NOS)
- ❑ Enteropathy-associated T-cell lymphoma
- ❑ Monomorphic epitheliotropic intestinal T-cell lymphoma
- ❑ Nodal peripheral T-cell lymphoma with TFH phenotype
- ❑ Follicular T-cell lymphoma
- ❑ Hepatosplenic gamma-delta T-cell lymphoma
- ❑ High-grade B-cell lymphoma
- ❑ Other _____

AIDS-Related Diffuse Large B-Cell Lymphoma

6. Will Revlimid be used as second-line or subsequent therapy for relapse of AIDS-related diffuse large B-cell lymphoma? ❑ Yes ❑ No

Primary Central Nervous System (CNS) Lymphoma, Nongastric MALT Lymphoma, Nodal Marginal Zone Lymphoma, Splenic Marginal Zone Lymphoma, Multicentric Castleman's Disease, Primary Cutaneous Anaplastic Large Cell Lymphoma (ALCL) or Cutaneous ALCL, Angioimmunoblastic T-Cell Lymphoma (AITL), Peripheral T-Cell Lymphoma NOS, Enteropathy-Associated T-Cell Lymphoma, Monomorphic Epitheliotropic Intestinal T-Cell Lymphoma, Nodal Peripheral T-Cell Lymphoma, Follicular T-Cell Lymphoma, Hepatosplenic Gamma-Delta T-Cell Lymphoma, High-Grade B-Cell Lymphomas

7. Which of the following does the patient have? ***Indicate ALL that apply.***
   ❑ Relapsed disease ❑ Progressive disease
   ❑ Refractory disease ❑ None of the above
   If the diagnosis is multicentric Castleman's disease, no further questions

8. How will Revlimid be used?
   ❑ As a single agent ❑ As second-line or subsequent therapy
   ❑ In combination with rituximab ❑ None of the above

Diffuse Large B-Cell Lymphoma

9. Has the patient received multiple lines of chemoimmunotherapy? ❑ Yes ❑ No

Non-Germinal Center Diffuse Large B-Cell Lymphoma, Gastric MALT Lymphoma, Adult T-Cell Leukemia/Lymphoma (acute or lymphoma subtypes), Post-Transplant Lymphoproliferative Disorder

10. Will Revlimid be used as second-line or subsequent therapy? ❑ Yes ❑ No

11. *If diagnosis is non-germinal center diffuse large B-cell lymphoma,* is the patient a candidate for transplant? ❑ Yes ❑ No

Section B: Myelodysplastic Syndrome

12. What is the International Prognostic Scoring System (IPSS) risk category of the disease?
    ❑ Low ❑ Intermediate-1 ❑ Intermediate-2 ❑ High

13. Prior to starting therapy with Revlimid, does the patient have symptomatic anemia? ❑ Yes ❑ No

14. Will Revlimid be used as a single agent? ❑ Yes ❑ No

Section C: Myelofibrosis-Associated Anemia

15. Will Revlimid be given as a single agent or in combination with prednisone? ❑ Yes ❑ No

16. What is the patient's serum erythropoietin level? _____mU/mL ❑ Unknown
    If greater than or equal to 500mU/mL, no further questions.

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17. Did the patient lose response to or not respond to erythropoietin stimulating agents? ❑ Yes ❑ No

Section D: Systemic Light Chain Amyloidosis and POEMS Syndrome

18. Will Revlimid be given in combination with dexamethasone? ❑ Yes ❑ No

Section E: Classical Hodgkin Lymphoma

19. Does the patient have relapsed or refractory disease? ❑ Yes ❑ No

20. What is the place in therapy? ❑ First line ❑ Second line ❑ Third line or subsequent

21. Will Revlimid be used as a single agent? ❑ Yes ❑ No

Section F: Myelodysplastic/Myeloproliferative Neoplasms

22. Will Revlimid be used as a single agent? ❑ Yes ❑ No

23. Will Revlimid be used in combination with a hypomethylating agent? ❑ Yes ❑ No

24. Does the neoplasm have ring sideroblasts and thrombocytosis? ❑ 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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