CVS caremark™ {{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.

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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 (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome
   - ❑ Myelodysplastic syndrome/myeloproliferative neoplasms
   - ❑ AIDS-related Kaposi Sarcoma
   - ❑ Smoldering Myeloma
   - ❑ 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 non-germinal center diffuse large B-cell lymphoma
   - ❑ Primary central nervous system (CNS) lymphoma
   - ❑ Monomorphic post-transplant lymphoproliferative disorder (non-germinal center B-cell type)
   - ❑ Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
   - ❑ Histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma
   - ❑ Diffuse large B-cell lymphoma, not otherwise specified
   - ❑ Follicular lymphoma
   - ❑ Mantle cell lymphoma

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- ❑ Nongastric MALT lymphoma
- ❑ Gastric MALT 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 T-cell lymphoma
- ❑ High-grade B-cell lymphoma
- ❑ Histologic transformation of follicular lymphoma to diffuse large B-cell lymphoma
- ❑ Other _____

AIDS-Related Non-Germinal Center Diffuse Large B-Cell Lymphoma

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

Primary Central Nervous System (CNS) Lymphoma, Multicentric Castleman's Disease, Primary Cutaneous Anaplastic Large Cell Lymphoma (ALCL) or Cutaneous ALCL

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

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

9. Will the requested drug be used as second-line or subsequent therapy, or as initial palliative therapy?
   ❑ Yes ❑ No

Histologic Transformation of Nodal Marginal Zone Lymphoma to Diffuse large B-cell lymphoma

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

Diffuse large B-cell lymphoma, not otherwise specified

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

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

Nongastric MALT Lymphoma, Gastric MALT Lymphoma, Adult T-Cell Leukemia/Lymphoma (acute or lymphoma subtypes), Monomorphic Post-Transplant Lymphoproliferative Disorder, Nongastric MALT Lymphoma, , Nodal Marginal Zone Lymphoma, Splenic Marginal Zone Lymphoma,

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

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

Section B: Myelodysplastic Syndrome

15. Does the patient have lower risk myelodysplastic syndrome (defined as Revised International Prognostic Scoring System (IPSS-R) (Very Low, Low, Intermediate), International Prognostic Scoring System (IPSS) (Low/Intermediate-1), WHO classification-based Prognostic Scoring System (WPSS) (Very Low, Low, Intermediate? ❑ Yes ❑ No
16. Prior to starting therapy with Revlimid, does the patient have symptomatic anemia? ❑ Yes ❑ No
17. Will Revlimid be used as a single agent? ❑ Yes ❑ No

Section C: Myelofibrosis-Associated Anemia

18. Will Revlimid be given as a single agent or in combination with prednisone? ❑ Yes ❑ No
19. What is the patient's serum erythropoietin level? _____mU/mL ❑ Unknown
    If greater than or equal to 500mU/mL, no further questions.
20. Did the patient lose response to or not respond to erythropoietin stimulating agents? ❑ Yes ❑ No

Section D: POEMS Syndrome

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

Section E: Classical Hodgkin Lymphoma

22. Does the patient have relapsed or refractory disease? ❑ Yes ❑ No
23. What is the place in therapy? ❑ First line ❑ Second line ❑ Third line or subsequent
24. Will Revlimid be used as a single agent? ❑ Yes ❑ No

Section F: Myelodysplastic/Myeloproliferative Neoplasms

25. Will Revlimid be used as a single agent? ❑ Yes ❑ No
26. Will Revlimid be used in combination with a hypomethylating agent? ❑ Yes ❑ No
27. Does the neoplasm have ring sideroblasts and thrombocytosis? ❑ Yes ❑ No

Section G: AIDS-Related Kaposi Sarcoma

28. Will the requested drug be used as subsequent therapy? ❑ Yes ❑ No

Section H: Hepatosplenic T-cell Lymphoma

29. Does the patient have refractory disease? ❑ Yes ❑ No
30. Will the requested drug be used as second line or subsequent therapy? ❑ Yes ❑ No

Section I: AIDS-Related Kaposi Sarcoma

31. Will the requested drug be used as subsequent therapy? ❑ Yes ❑ No
32. Will the requested drug be given with antiretroviral therapy (ART)? ❑ Yes ❑ No

Section J: Smoldering Myeloma

33. Will the requested drug be used for treatment of asymptomatic high-risk disease? ❑ 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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