Sylvant

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: ____
Specialty: __________________________________ **NPI#:** __________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ____________________
Request Initiated For: _______________________

1. What is the diagnosis?
   ❑ Multicentric Castleman's disease
   ❑ Unicentric Castleman's disease
   ❑ 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 #5.*
4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions.*
5. What is the patient's human immunodeficiency virus (HIV) status? ❑ Positive ❑ Negative ❑ Unknown
6. What is the patient's human herpesvirus-8 (HHV-8) status? ❑ Positive ❑ Negative ❑ Unknown
7. Will Sylvant be used as a single agent? ❑ Yes ❑ No

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

Section A: Multicentric Castleman's Disease

8. Does the patient have active multicentric Castleman's disease with no organ failure? ❑ Yes ❑ No

Section B: Unicentric Castleman's Disease

9. Does the patient have relapsed or refractory 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)**

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
Phone: 1-866-814-5506 ● Fax: 1-866-249-6155 ● www.caremark.com