Treanda, Bendeka, Belrapzo

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.

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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:** _____

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*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Criteria Questions:

1. What drug is being prescribed? ❑ Treanda ❑ Bendeka ❑ Belrapzo ❑ Other _____

2. What is the diagnosis?
   - ❑ Follicular lymphoma
   - ❑ Chronic lymphocytic leukemia (CLL) without chromosome 17p deletion or without TP53 mutation
   - ❑ Small lymphocytic lymphoma (SLL) without chromosome 17p deletion or without TP53 mutation
   - ❑ Diffuse large B-cell lymphoma (DLBCL)
   - ❑ Adult T-cell leukemia/lymphoma (ATLL)
   - ❑ AIDS-related B-cell lymphoma
   - ❑ Marginal zone lymphoma (nodal, gastric MALT, non-gastric MALT, splenic)
   - ❑ Mantle cell lymphoma (MCL)
   - ❑ Mycosis Fungoides (MF)
   - ❑ Sezary syndrome (SS)
   - ❑ Peripheral T-cell Lymphoma (PTCL) [including the following subtypes: anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with TFH phenotype, or follicular T-cell lymphoma
   - ❑ Cutaneous anaplastic large cell lymphoma (ALCL)
   - ❑ Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma
   - ❑ Multiple myeloma
   - ❑ Classical Hodgkin lymphoma
   - ❑ Post-transplant lymphoproliferative disorders
   - ❑ Histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma
   - ❑ Histologic transformation of follicular lymphoma to diffuse large B-cell lymphoma without translocations of MYC and BCL2 and/or BCL6
   - ❑ High grade B-cell lymphoma
   - ❑ Hepatosplenic T-Cell lymphoma
   - ❑ Breast implant associated anaplastic large cell lymphoma (ALCL)
   - ❑ Nodular lymphocyte predominant Hodgkin lymphoma (NLPHL)
   - ❑ Other _____

3. What is the ICD-10 code? _____

4. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #6*

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

6. What is the requested regimen? *Indicate ALL that apply.*
   - ❑ The requested drug will be used as a single agent
   - ❑ The requested drug will be used as subsequent therapy
   - ❑ The requested drug will be used as palliative therapy
   - ❑ The requested drug will be used in combination with rituximab
   - ❑ The requested drug will be used in combination with obinutuzumab (Gazyva)
   - ❑ The requested drug will be used in combination with lenalidomide (Revlimid) and dexamethasone
   - ❑ The requested drug will be used in combination with bortezomib (Velcade) and dexamethasone
   - ❑ The requested drug will be used in combination with brentuximab vedotin (Adcetris)
   - ❑ The requested drug will be used in combination with gemcitabine and vinorelbine
   - ❑ The requested drug will be used in combination with carboplatin and etoposide
   - ❑ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy)
   - ❑ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy) and rituximab
   - ❑ The requested drug will be used as a component of RBAC500 (rituximab, bendamustine, and cytarabine)
   - ❑ None of the above

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

Section A: Diffuse Large B-Cell Lymphoma (DLBCL)

7. Will the requested drug be used as a bridging option until CAR T-cell product is available? ❑ Yes ❑ No

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

Section B: High-Grade B-Cell Lymphoma, AIDS-Related B-Cell Lymphoma

9. Will the requested drug be used as a bridging option until CAR T-cell product is available?
   ❑ Yes *If Yes, no further questions* ❑ No

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

Section C: Histologic Transformation of Nodal Marginal Zone Lymphoma to Diffuse Large B-Cell Lymphoma

11. How many previous lines of chemoimmunotherapy has the patient received? _____ lines

Section D: Cutaneous Anaplastic Large Cell Lymphoma (ALCL)

12. Is the disease relapsed or refractory? ❑ Yes ❑ No

Section E: Post Transplant Lymphoproliferative disorders

13. Will the requested drug be used as a bridging option until CAR T-cell product is available? ❑ Yes ❑ No

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

Hepatosplenic T-Cell lymphoma

15. Is the disease refractory? ❑ Yes ❑ No

Section F: Multiple Myeloma

16. Is the disease relapsed or progressive? ❑ 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 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