



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 Inpatient Hospital 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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Treanda Bendeka, Belrapzo SGM -10/2020.

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

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)
 - 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 gamma-delta T-Cell lymphoma
 - 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 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. How many prior therapies has the patient received? _____ therapies
8. Is the patient a candidate for transplant? Yes No

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

9. Is the patient a candidate for transplant? Yes No

Section C: Histologic Transformation of Nodal Marginal Zone Lymphoma to Diffuse Large B-Cell Lymphoma and Histologic Transformation of Follicular Lymphoma to Diffuse Large B-Cell Lymphoma without translocations of MYC and BCL2 and/or BCL6

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

Section D: Cutaneous Anaplastic Large Cell Lymphoma (ALCL) or Hepatosplenic Gamma-Delta T-Cell Lymphoma

11. Is the disease: Relapsed Refractory
 None of the above

Section E: Multiple Myeloma

12. 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)

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