Ukoniq

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: _____ **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?
   - ❑ Marginal zone lymphoma (MZL)
   - ❑ Follicular lymphoma (FL)
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. These are the preferred products for which coverage is provided for the treatment of the following indications:
   a) Follicular lymphoma: **Copiktra**
   b) Marginal zone lymphoma: **Imbruvica**
   Can the patient's treatment be switched to a preferred product?

   ❑ Yes - Please specify: _____ ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ No - Continue request for Ukoniq

4. Has the patient had a documented intolerable adverse event or contraindication to treatment with any of the following preferred products? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   Indicate ALL that apply.
   - ❑ Copiktra: ❑ Intolerable adverse event ❑ Contraindication to treatment
   - ❑ Imbruvica: ❑ Intolerable adverse event ❑ Contraindication to treatment
   - ❑ None of the above

5. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #7*

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

7. Is the patient's disease relapsed or refractory? ❑ Yes ❑ No

8. Will the requested medication be used as a single agent? ❑ Yes ❑ No

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

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

Section A: Marginal zone lymphoma (MZL)

9. Has the patient received at least one prior anti-CD-20 based regimen (e.g., rituximab, obinutuzumab)?
   ❑ Yes ❑ No

Section B: Follicular lymphoma (FL)

10. Has the patient received at least three prior lines of systemic therapy? ❑ 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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