CareFirst
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

Velcade (for Maryland only)

Prior Authorization Request

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

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 **1-866-814-5506.** 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.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Multiple Myeloma
   - ❑ Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma
   - ❑ Mantle Cell Lymphoma
   - ❑ Systemic Light Chain Amyloidosis
   - ❑ Castleman's Disease
   - ❑ Other _____

2. What is the ICD-10 code? _____
   If patient's diagnosis is mantle cell lymphoma, systemic light chain amyloidosis or Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma, no further questions.

3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*

4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ACTION REQUIRED: ***Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***

5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*

6. What is the prescribed regimen?
   - ❑ Velcade monotherapy
   - ❑ Velcade, melphalan and prednisone
   - ❑ Velcade and rituximab
   - ❑ Other _____

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

Section A: Multiple Myeloma

7. What is the intent of treatment? ***If intent is Maintenance or Salvage therapy, no further questions.***
   ❑ Primary therapy ❑ Maintenance therapy ❑ Salvage therapy

8. Will the prescribed regimen include dexamethasone? *If Yes, no further questions* ❑ Yes ❑ No

9. Is the member a candidate for stem cell transplantation? ❑ Yes ❑ No

Section B: Castleman's Disease

10. Did the disease progress following treatment of relapsed, refractory, or progressive disease? ❑ Yes ❑ No

11. What is the form of the disease? ❑ Unicentric ❑ Multicentric

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)**