Velcade (bortezomib)

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.

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:** _____

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

 Velcade (bortezomib) SGM – 05/2021.

Criteria Questions:

1. What drug is being prescribed?
   - ❑ Velcade
   - ❑ bortezomib

2. What is the patient's diagnosis?
   - ❑ Multiple myeloma
   - ❑ Mantle cell lymphoma
   - ❑ Multicentric Castleman's disease
   - ❑ Systemic light chain amyloidosis
   - ❑ Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma
   - ❑ Adult T-cell leukemia/lymphoma
   - ❑ Antibody mediated rejection of solid organ
   - ❑ Acute lymphoblastic leukemia
   - ❑ Follicular Lymphoma
   - ❑ AIDS-related Kaposi's sarcoma
   - ❑ Hodgkin Lymphoma
   - ❑ POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome
   - ❑ Other _____

3. What is the ICD-10 code? _____

4. What is the patient's height in inches? _____inches

5. What is the patient's weight in pounds? _____pounds

6. What is the patient's Body Surface Area (BSA)? (Note average adult BSA is around 1.7 m2) _____

7. What is the patient's dose in milligrams? _____mg

8. Will the patient's dose exceed 1.6 mg/m2? ❑ Yes ❑ No

9. Does the member require more than 7 doses per 30 day period? ❑ Yes ❑ No

10. Is this a request for continuation of therapy with the requested drug?
    ❑ Yes ❑ No *If No, skip to diagnosis section*

11. Has the patient experienced unacceptable toxicity or disease progression while on the current regimen?
    ❑ Yes ❑ No *No further questions*

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

Section A: Multicentric Castleman's Disease

12. Is the patient's disease relapsed, refractory, or progressive? ❑ Yes ❑ No

Section B: Systemic Light Chain Amyloidosis and Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma

13. What is the prescribed regimen?
    - ❑ The requested medication in combination with melphalan and dexamethasone
    - ❑ The requested medication in combination with cyclophosphamide and dexamethasone
    - ❑ The requested medication in combination with dexamethasone
    - ❑ The requested medication in combination with lenalidomide and dexamethasone
    - ❑ The requested medication in combination with daratumumab and hyaluronidase-fihj, cyclophosphamide, and dexamethasone
    - ❑ The requested medication in combination with rituximab
    - ❑ The requested medication in combination with rituximab and dexamethasone
    - ❑ The requested medication as a single agent
    - ❑ Other_____

Section C: Adult T-Cell Leukemia/Lymphoma

14. Will the requested medication be used as a single agent for second-line or subsequent therapy? ❑ Yes ❑ No

Section D: Acute Lymphoblastic Leukemia
15. Is the patient's disease relapsed or refractory? ❑ Yes ❑ No

Section E: Follicular Lymphoma
16. Is the patient's disease relapsed or refractory? ❑ Yes ❑ No

Section F: AIDS-Related Kaposi's Sarcoma
17. Is the patient's disease relapsed or refractory? ❑ Yes ❑ No

18. Will the requested medication be used in combination with antiretroviral therapy (ART)? ❑ Yes ❑ No

Section G: Hodgkin Lymphoma
19. Is the patient's disease relapsed or refractory? ❑ Yes ❑ No

Section H: POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome
20. Will the requested medication be used in combination with dexamethasone? ❑ 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