Adcetris

CareFirst 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*

What is the ICD-10 code? _____

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

 Adcetris SGM 1700-A – 12/2024

Criteria Questions:

1. What is the diagnosis?

❒ Classic Hodgkin lymphoma (cHL), *Continue to 2*

❒ Systemic anaplastic large cell lymphoma (ALCL), *Continue to 2*

❒ Cutaneous anaplastic large cell lymphoma (cALCL), *Continue to 2*

❒ Adult T-cell leukemia/lymphoma, *Continue to 2*

❒ Breast implant associated anaplastic large cell lymphoma (ALCL), *Continue to 2*

❒ Lymphomatoid papulosis (LyP), *Continue to 2*

❒ 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], *Continue to 2*

❒ Mycosis fungoides (MF), *Continue to 2*

❒ Sezary Syndrome (SS), *Continue to 2*

❒ Diffuse large B-cell lymphoma, *Continue to 2*

❒ Extranodal NK/T-cell Lymphoma, *Continue to 2*

❒ Hepatosplenic T-cell lymphoma, *Continue to 2*

❒ High-grade B-Cell lymphomas, *Continue to 2*

❒ HIV-related B-Cell lymphomas (CD30+ HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma), *Continue to 2*

❒ Monomorphic post-transplant lymphoproliferative disorders (B-cell type), *Continue to 2*

❒ Pediatric primary mediastinal large B-cell lymphoma, *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Has testing or analysis been completed which confirms CD30 expression on the surface of the cell? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or test results indicating CD30 positive disease.

❒ Yes, *Continue to 3*

❒ No, *Continue to 3*

3. Is this a request for continuation of therapy with the requested drug?

❒ Yes, *Continue to 4*

❒ No, *Continue to 5*

4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

5. What is the diagnosis?

❒ Classic Hodgkin lymphoma (cHL), *Continue to 6*

❒ Systemic anaplastic large cell lymphoma (ALCL), *Continue to 8*

❒ Cutaneous anaplastic large cell lymphoma, *Continue to 8*

❒ Adult T-cell leukemia/lymphoma, *Continue to 21*

❒ Breast implant associated anaplastic large cell lymphoma, *Continue to 8*

❒ Lymphomatoid papulosis (LyP), *Continue to 9*
❒ 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], *Continue to 23*

❒ Mycosis fungoides (MF), *No further questions*

❒ Sezary Syndrome (SS), *No further questions*

❒ Diffuse large B-cell lymphoma, *Continue to 11*

❒ Extranodal NK/T-cell Lymphoma, *Continue to 13*

❒ Hepatosplenic T-cell lymphoma, *Continue to 17*

❒ High-grade B-Cell lymphomas, *Continue to 11*
❒ HIV-related B-Cell lymphomas (CD30+ HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma), *Continue to 11*

❒ Monomorphic post-transplant lymphoproliferative disorders (B-cell type), *Continue to 19*

❒ Pediatric primary mediastinal large B-cell lymphoma, *Continue to 25*

6. What is the requested regimen?

❒ The requested drug will be used as a single agent, *No further questions*
❒ The requested drug will be used in combination with doxorubicin, vinblastine, and dacarbazine, *No further questions*

❒ The requested drug will be used in combination with bendamustine, *Continue to 7*

❒ The requested drug will be used in combination with dacarbazine, *No further questions*

❒ The requested drug will be used in combination with nivolumab, *Continue to 7*

❒ The requested drug will be used in combination with gemcitabine, *Continue to 7*

❒ The requested drug will be used in combination with ifosfamide, carboplatin and etoposide, *Continue to 7*
❒ The requested drug will be used in combination with cyclophosphamide, prednisone, and dacarbazine, *Continue to 7*
❒ The requested drug will be used in combination with etoposide, prednisone and doxorubicin, *No further questions*
❒ The requested drug will be used in combination with doxorubicin, vincristine, etoposide, prednisone and cyclophosphamide, *No further questions*
❒ The requested drug will be used in combination with etoposide, cyclophosphamide, doxorubicin, dacarbazine and dexamethasone, *No further questions*

❒ Other, please specify. _____, *Continue to 7*

7. What is the place in therapy in which the requested drug will be used?

❒ Initial therapy, *No further questions*

❒ Subsequent therapy, *No further questions*

8. What is the requested regimen?

❒ The requested drug will be used as a single agent, *No further questions*
❒ The requested drug will be used in combination with cyclophosphamide, doxorubicin, and prednisone (CHP), *No further questions*

❒ Other, please specify. _____, *No further questions*

9. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is the disease relapsed or refractory?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

11. What is the place in therapy in which the requested drug will be used?

❒ Initial therapy, *Continue to 12*

❒ Subsequent therapy, *Continue to 12*

12. Is the patient a candidate for transplant?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

13. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Is the disease relapsed or refractory?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Has the patient had an inadequate response to asparaginase-based therapy (e.g., pegaspargase)?
❒ Yes, *No Further Questions*
❒ No, *Continue to 16*

16. Does the patient have a contraindication to asparaginase-based therapy (e.g., pegaspargase)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

17. What is the requested regimen?

❒ The requested drug will be used as a single agent, *Continue to 18*

❒ Other, please specify. _____, *Continue to 18*

18. How many previous lines of primary treatment regimens has the patient received?

❒ 0, *No further questions*

❒ 1, *No further questions*
❒ 2 or more; please indicate the number of regimens the patient has received: _____, *No further questions*

19. What is the place in therapy in which the requested drug will be used?

❒ Initial therapy, *Continue to 20*

❒ Subsequent therapy, *Continue to 20*

20. Is the patient a candidate for transplant?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

21. What is the requested regimen?

❒ The requested drug will be used as a single agent, *Continue to 22*
❒ The requested drug will be used in combination with cyclophosphamide, doxorubicin, and prednisone, *No further questions*

❒ Other, please specify. _____, *Continue to 22*

22. What is the place in therapy in which the requested drug will be used?

❒ Initial, *No further questions*

❒ Subsequent, *No further questions*

23. What is the requested regimen?

❒ The requested drug will be used as a single agent, *Continue to 24*
❒ The requested drug will be used in combination with cyclophosphamide, doxorubicin, and prednisone, *No further questions*

❒ Other, please specify. _____, *Continue to 24*

24. What is the place in therapy in which the requested drug will be used?

❒ Subsequent therapy, *No further questions*

❒ Palliative therapy, *No further questions*

❒ Other, please specify. _____, *No further questions*

25. Is the disease relapsed or refractory?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Will the requested drug be used in combination with nivolumab or pembrolizumab?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

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