# Beleodaq

## 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**

 CareFirst Beleodaq SGM 1701-A – 07/2025.

**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 is the diagnosis?

❒ 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*

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

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

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

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

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

2. Is this a request for continuation of therapy with the requested medication?

❒ Yes, *Continue to 3*

❒ No, *Continue to 4*

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

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

4. What is the diagnosis?

❒ 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 5*

❒ Adult T-cell leukemia/lymphoma (ATLL), *Continue to 8*

❒ Extranodal NK/T-cell lymphoma, *Continue to 10*

❒ Hepatosplenic T-cell lymphoma, *Continue to 14*

❒ Breast implant-associated anaplastic large cell lymphoma (ALCL), *Continue to 16*

5. Will the requested medication be used as a single agent?

❒ Yes, *Continue to 6*

❒ No, *Continue to 6*

6. Is the disease relapsed or refractory?

❒ Yes, *No Further Questions*

❒ No, *Continue to 7*

7. Is the requested medication being used for palliative intent?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

8. Will the requested medication be used as a single agent?

❒ Yes, *Continue to 9*

❒ No, *Continue to 9*

9. What is the place in therapy in which the requested medication will be used?

❒ First-line treatment, *No Further Questions*
❒ Subsequent treatment, *No Further Questions*

10. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is the disease relapsed or refractory?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Has the patient had an inadequate response to asparaginase-based therapy (e.g., pegaspargase)?
❒ Yes, *No Further Questions*
❒ No, *Continue to 13*

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

14. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. How many previous lines of chemotherapy has the patient received?
_____ lines, *No Further Questions*

16. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. What is the place in therapy in which the requested medication will be used?

❒ First-line treatment, *No Further Questions*

❒ Subsequent treatment, *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)**

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