Breyanzi

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

 Breyanzi SGM 4513-A - 11/2024.

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?

❒ Adult Large B-cell Lymphoma, *Continue to 2*

❒ Pediatric Primary Mediastinal Large B-cell Lymphoma, *Continue to 10*

❒ Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL), *Continue to 13*

❒ Other, please specify. _____, *No Further Questions*

2. Is the patient 18 years of age or older?

❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Will the requested drug be used to treat Mantle cell lymphoma?

❒ Yes, *Continue to 4*
❒ No, *Continue to 6*

4. What is the clinical setting in which the requested drug will be used?

❒ Relapsed disease, *Continue to 5*

❒ Refractory disease, *Continue to 5*

❒ Other, please specify. _____, *Continue to 5*

5. Has the patient received prior treatment with a covalent Bruton tyrosine kinase inhibitor (e.g., acalabrutinib [Calquence], ibrutinib [Imbruvica], zanubrutinib [Brukinsa])? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical records or claim history supporting previous lines of therapy.

❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

6. Does the patient have any of the following B-cell lymphoma subtypes?

❒ Diffuse large B-cell lymphoma (DLBCL) arising from indolent lymphomas, *Continue to 9*
❒ Diffuse large B-cell lymphoma (DLBCL) [including DLBCL NOS and follicular lymphoma grade 3], *Continue to 7*
❒ High grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified), *Continue to 7*

❒ Primary mediastinal large B-cell lymphoma, *Continue to 7*
❒ HIV-related B-cell lymphomas (including HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specified), *Continue to 7*

❒ Monomorphic post-transplant lymphoproliferative disorder (B-cell type), *Continue to 7*

❒ Follicular lymphoma, *Continue to 9*

❒ Other, please specify. _____, *No Further Questions*

7. Has the patient received prior treatment with first-line chemoimmunotherapy (e.g., RCHOP [rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone])? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical records, or claims history supporting previous lines of therapy.

❒ Yes, *Continue to 16*
❒ No, *Continue to 8*

8. Has the patient received prior treatment with two or more lines of systemic therapy? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical records or claims history supporting previous lines of therapy.

❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

9. Has the patient received prior treatment with two or more lines of systemic therapy? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical records or claims history supporting previous lines of therapy.
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

10. Is the patient less than 18 years of age?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Has the patient received prior treatment with first-line chemoimmunotherapy (e.g., RCHOP [rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone])? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical records, or claims history supporting previous lines of therapy.
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Has the patient achieved partial response?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

13. Is the patient 18 years of age or older?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. What is the clinical setting in which the requested drug will be used?

❒ Relapsed disease, *Continue to 15*

❒ Refractory disease, *Continue to 15*

❒ Other, please specify. _____, *Continue to 15*

15. Has the patient received prior treatment with Bruton tyrosine kinase inhibitor (e.g., acalabrutinib [Calquence], ibrutinib [Imbruvica], zanubrutinib [Brukinsa]) and venetoclax-based regimens)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical records, or claims history supporting previous lines of therapy.
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Does the patient have primary central nervous system lymphoma?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Does the patient have adequate and stable kidney, liver, pulmonary and cardiac function?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Does the patient have active hepatitis B, active hepatitis C, or any active uncontrolled infection?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Does the patient have active graft versus host disease?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Does the patient have an active inflammatory disorder?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2 (the patient is ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours)?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. Has the patient received a previous treatment course of the requested medication or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy (e.g., Yescarta, Kymriah)?
[Check the patient's PA history to ensure the patent has not had one previous course of Breyanzi or another CD19-directed CAR T-cell therapy.]
❒ 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)**

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 Breyanzi SGM 4513-A - 11/2024.

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