2211 Sanders Road, Northbrook, IL 60062 Phone (866) 814-5506

Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}

To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (855) 330-1720

Re: Prior Authorization for {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}

Electronically (4-5 **minutes** process time)	Phone (10-15 **minutes** process time)	Fax (24-72 **hours** process time)
CVS/Caremark now accepts PA requests on-line 24/7. No fax machines, no phone hold times, faster approval. Most requests will not require a fax or phone call. To request a Prior Authorization online, navigate to https://provider.carefirst.com/providers/home.page and click on the orange tab in the upper right hand corner; or for more details about how to submit and review your prior authorization requests online, view the training video available at www.carefirst.com/learninglibrary > Pharmacy.	Calling us with your PA request during our business hours is another option The process over the phone can take between 10 and 15 minutes. OR online	You may also continue to fax us your PA request Faxes received are processed within 24 to 72 hours. OR online

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Darzalex

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 Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}
Patient's ID: {Auth.Member.MemberID}

Date: {System.DateTime.Today}

Patient's Date of Birth: {Auth.Member.MemberBirthDate}

Physician's Name: {Auth.ProviderBilling.Name.Legal}
Specialty: _____
Physician Office Telephone: {Auth.OfficeContactPhoneNumber}

NPI#: {Auth.ProviderBilling.NPI}
Physician Office Fax: {Auth.OfficeContactFaxNumber}

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

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Criteria Questions:

1. What is the diagnosis?

❒ Multiple myeloma, *Continue to 2*
❒ POEMS (Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal protein, Skin changes) Syndrome, *Continue to 3*
❒ Systemic light chain amyloidosis, *Continue to 3*
❒ T- cell acute lymphoblastic leukemia (T-ALL), *Continue to 3*
❒ Other, please specify. _____, *No further questions*

2. Will the requested drug be used in combination with bortezomib, thalidomide, and dexamethasone?
❒ Yes, *Continue to 10*
❒ 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. Has the patient experienced unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

5. What is the diagnosis?

❒ Multiple myeloma, *Continue to 6*
❒ POEMS (Polyneuropathy, Organomegaly, Endocrinopathy, Monoclonal protein, Skin changes) Syndrome, *Continue to 29*
❒ Systemic light chain amyloidosis, *Continue to 25*
❒ T- cell acute lymphoblastic leukemia (T-ALL), *Continue to 27*

6. What is the prescribed regimen?

❒ The requested drug in combination with pomalidomide and dexamethasone, *Continue to 7*
❒ The requested drug as a single agent, *Continue to 8*
❒ The requested drug in combination with bortezomib, lenalidomide, and dexamethasone, *Continue to 11*
❒ The requested drug in combination with carfilzomib, lenalidomide, and dexamethasone, *Continue to 11*
❒ The requested drug in combination with bortezomib, melphalan, and prednisone, *Continue to 13*
❒ The requested drug in combination with selinexor and dexamethasone, *Continue to 15*
❒ The requested drug in combination with venetoclax and dexamethasone, *Continue to 16*
❒ The requested drug in combination with bortezomib and dexamethasone, *Continue to 18*
❒ The requested drug in combination with carfilzomib and dexamethasone, *Continue to 18*
❒ The requested drug in combination with cyclophosphamide, bortezomib, and dexamethasone, *No further questions*
❒ The requested drug in combination with lenalidomide and dexamethasone, *Continue to 19*
❒ The requested drug in combination with lenalidomide, *Continue to 22*
❒ The requested drug with carfilzomib, pomalidomide, and dexamethasone, *Continue to 15*
❒ Other, please specify. _____, *No further questions*

7. Has the patient received at least one prior regimen, including a proteasome inhibitor (PI) (e.g., Velcade) and an immunomodulatory agent (e.g., Revlimid)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

8. Has the patient received at least three prior regimens, including a proteasome inhibitor (PI) (e.g., Velcade) and an immunomodulatory agent (e.g., Revlimid)?
❒ Yes, *No Further Questions*
❒ No, *Continue to 9*

9. Is the patient double refractory to a proteasome inhibitor (PI) (e.g., Velcade) and an immunomodulatory agent (e.g., Revlimid)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

10. Will the requested drug be used for a maximum of 16 doses?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is the patient eligible for transplant?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Will the requested drug be used as primary therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

13. Is the patient eligible for transplant?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Will the requested drug be used as primary therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

15. Has the patient been previously treated for multiple myeloma?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

16. Does the patient have a documented t(11:14) translocation? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results of t(11:14) translocation.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 17*
❒ No, *Continue to 17*
❒ Unknown, *Continue to 17*

17. Has the patient been previously treated for multiple myeloma?

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

18. Has the patient received at least one prior regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

19. Is the patient eligible for transplant?
❒ Yes, *Continue to 21*
❒ No, *Continue to 20*

20. Will the requested drug be used as primary therapy?
❒ Yes, *No Further Questions*
❒ No, *Continue to 21*

21. Has the patient received at least one prior regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

22. Will the requested drug be used for maintenance therapy?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Is the requested drug being used to treat symptomatic multiple myeloma?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

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

25. What is the requested regimen?
❒ The requested drug in combination with bortezomib, cyclophosphamide and dexamethasone, *No further questions*
❒ As a single agent, *No further questions*
❒ The requested drug in combination with lenalidomide and dexamethasone, *Continue to 26*
❒ Other, please specify. _____, *Continue to 26*

26. What is the clinical setting in which the requested drug will be used?
❒ Relapsed disease, *No further questions*
❒ Refractory disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

27. What is the clinical setting in which the requested drug will be used?
❒ Relapsed disease, *Continue to 28*

❒ Refractory disease, *Continue to 28*

❒ Other, please specify. _____, *Continue to 28*

28. What is the prescribed regimen?
❒ The requested drug in combination with vincristine, pegaspargase, doxorubicin, and prednisone or dexamethasone, *No further questions*
❒ The requested drug in combination with vincristine, calaspargase, doxorubicin, and prednisone or dexamethasone, *No further questions*
❒ Other, please specify. _____, *No further questions*

29. Will the requested drug be used in combination with lenalidomide and dexamethasone?
❒ Yes, *Continue to 30*
❒ No, *Continue to 30*

30. Will the requested drug be used as induction therapy?
❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

31. Is the patient a transplant candidate?
❒ 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