Gazyva

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

 Gazyva SGM 2075-A – 02/2025.

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. Is this a request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 2*
❒ No, *Continue to 5*

2. Is there evidence of disease progression or unacceptable toxicity while on the current regimen?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. What is the patient's diagnosis?

❒ Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL), *No further questions*

❒ Follicular lymphoma (FL), *Continue to 4*

❒ Extranodal marginal zone lymphoma (gastric MALT lymphoma), *No further questions*

❒ Extranodal marginal zone lymphoma (non-gastric MALT lymphoma), *No further questions*

❒ Nodal marginal zone lymphoma, *No further questions*

❒ Splenic marginal zone lymphoma, *No further questions*

❒ Hairy cell leukemia, *No further questions*
❒ B-Cell Lymphomas (diffuse large B-cell lymphoma, high-grade B-cell lymphomas, histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, HIV-related B-cell lymphomas and post-transplant lymphoproliferative disorders) when used as pre- treatment with glofitamab (Columvi), *Continue to 23*

❒ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, *No further questions*

❒ Mantle cell lymphoma (MCL), *No further questions*

❒ Diffuse large B-cell lymphoma, *No further questions*
❒ 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), *No further questions*

❒ Burkitt lymphoma, *No further questions*

❒ HIV-related B-cell lymphoma, *No further questions*

❒ Post-transplant lymphoproliferative disorder, *No further questions*

❒ Castleman's Disease, *No further questions*

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

4. How many months of therapy with the requested medication has the patient received in their current course of therapy?

_____months, *No further questions*

5. What is the patient's diagnosis?

❒ Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL), *Continue to 18*

❒ Follicular lymphoma (FL), *Continue to 6*

❒ Extranodal marginal zone lymphoma (gastric MALT lymphoma), *Continue to 13*

❒ Extranodal marginal zone lymphoma (non-gastric MALT lymphoma), *Continue to 13*

❒ Nodal marginal zone lymphoma, *Continue to 14*

❒ Splenic marginal zone lymphoma, *Continue to 13*

❒ Hairy Cell Leukemia, *Continue to 20*

❒ B-Cell Lymphomas (diffuse large B-cell lymphoma, high-grade B-cell lymphomas, histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, HIV-related B-cell lymphomas and post-transplant lymphoproliferative disorders) when used as pre- treatment with glofitamab (Columvi), *Continue to 23*

❒ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, *Continue to 16*

❒ Mantle cell lymphoma (MCL), *Continue to 25*

❒ Diffuse large B-cell lymphoma, *Continue to 16*

❒ 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 16*

❒ Burkitt lymphoma, *Continue to 16*

❒ HIV-related B-cell lymphoma, *Continue to 16*

❒ Post-transplant lymphoproliferative disorder, *Continue to 16*

❒ Castleman's Disease, *Continue to 16*

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

6. How will the requested medication be used?

❒ The requested medication will be used as first line therapy, *Continue to 8*

❒ The requested medication will be used as subsequent therapy, *Continue to 9*

❒ The requested medication will be used as maintenance therapy, *Continue to 10*

❒ The requested medication will be used as a substitute for rituximab, *Continue to 7*

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

7. Has the patient experienced intolerance or rare complications from rituximab such as mucocutaneous reactions including paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis? Note: Re-challenge with the same anti-CD20 monoclonal antibody is not recommended and it is unclear if the use of an alternative anti-CD20 monoclonal antibody poses the same risk of recurrence.

❒ Yes, *Continue to 12*

❒ No, *Continue to 12*

8. Will the requested drug be used in combination with any of the following?

❒ CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone), *Continue to 12*

❒ CVP (cyclophosphamide, vincristine and prednisone), *Continue to 12*

❒ Bendamustine, *Continue to 12*

❒ Other, please specify. _____, *Continue to 12*

9. In which of the following regimens will the requested drug be used?

❒ In combination with CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone), *Continue to 12*

❒ In combination with CVP (cyclophosphamide, vincristine and prednisone), *Continue to 12*

❒ In combination with bendamustine, *Continue to 12*

❒ In combination with lenalidomide, *Continue to 12*

❒ As a single agent, *Continue to 12*

❒ In combination with zanubrutinib, *Continue to 11*

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

10. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

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

❒ First-line treatment, *Continue to 12*

❒ Second-line treatment, *Continue to 12*

❒ Third-line and subsequent therapy, *Continue to 12*

12. How many months of therapy with the requested medication has the patient received in their current course of therapy?

_____months, *No further questions*

13. How will the requested medication be used?
❒ The requested medication will be used as subsequent therapy in combination with bendamustine, *No further questions*
❒ The requested medication will be used as subsequent therapy in combination with lenalidomide, *No further questions*
❒ The requested medication will be used as maintenance therapy in a patient who has been treated with the requested medication and bendamustine, *No further questions*

❒ The requested medication will be used as a substitute for rituximab, *Continue to 17*

❒ Other, please specify. _____, *Continue to 17*

14. How will the requested medication be used?

❒ The requested medication will be used as first-line therapy, *Continue to 15*
❒ The requested medication will be used as subsequent therapy in combination with bendamustine, *No further questions*
❒ The requested medication will be used as subsequent therapy in combination with lenalidomide, *No further questions*
❒ The requested medication will be used as maintenance therapy in a patient who has been treated with the requested medication and bendamustine, *No further questions*

❒ The requested medication will be used as a substitute for rituximab, *Continue to 17*

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

15. Will the requested drug be used in combination with any of the following?

❒ CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) regimen, *No further questions*

❒ CVP (cyclophosphamide, vincristine and prednisone) regimen, *No further questions*

❒ Bendamustine, *No further questions*

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

16. Will the requested medication be used as a substitute for rituximab?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Has the patient experienced intolerance or rare complications from rituximab such as mucocutaneous reactions including paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis? Note: Re-challenge with the same anti-CD20 monoclonal antibody is not recommended and it is unclear if the use of an alternative anti-CD20 monoclonal antibody poses the same risk of recurrence.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

18. How will the requested medication be used?

❒ The requested medication will be used as a single agent, *No further questions*

❒ The requested medication will be used in combination with acalabrutinib, *No further questions*

❒ The requested medication will be used in combination with venetoclax, *No further questions*

❒ The requested medication will be used in combination with bendamustine, *No further questions*

❒ The requested medication will be used in combination with chlorambucil, *No further questions*

❒ The requested medication will be used in combination with high-dose methylprednisolone, *Continue to 19*

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

19. Are Bruton Tyrosine Kinase inhibitor (e.g. acalabrutinib) and venetoclax not available, or contraindicated, or rapid disease de-bulking is needed?
❒ Yes, Bruton Tyrosine Kinase inhibitor (e.g. acalabrutinib) and venetoclax are not available, *No further questions*
❒ Yes, Bruton Tyrosine Kinase inhibitor (e.g. acalabrutinib) and venetoclax are contraindicated, *No further questions*

❒ Yes, rapid disease de-bulking is needed, *No further questions*

❒ None of the above, *No further questions*

20. Will the requested drug be used in combination with any of the following?

❒ The requested medication will be used in combination with vemurafenib, *Continue to 21*

❒ Other, please specify. _____, *Continue to 21*

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

❒ Initial therapy, *Continue to 22*

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

22. Is the patient able to tolerate purine analogs?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

23. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Will the patient receive the requested medication as pre-treatment for up to 1 dose in cycle 1 of glofitamab (Columvi) therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

25. Does the patient have TP53 mutations? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming TP53 mutations.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 26*

❒ No, *Continue to 28*

❒ Unknown, *Continue to 28*

26. Will the requested medication be used as induction therapy?
❒ Yes, *Continue to 27*
❒ No, *Continue to 27*

27. Will the requested medication be used in combination with Venclexta (venetoclax) and Brukinsa (zanubrutinib)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

28. Will the requested medication be used as a substitute for rituximab?
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

29. Has the patient experienced intolerance or rare complications from rituximab such as mucocutaneous reactions including paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis? Note: Re-challenge with the same anti-CD20 monoclonal antibody is not recommended and it is unclear if the use of an alternative anti-CD20 monoclonal antibody poses the same risk of recurrence.
❒ 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)**