Polivy

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Polivy SGM 3095-A – 12/2024.

Criteria Questions:

1. What is the diagnosis?

❒ Diffuse large B-cell lymphoma (DLBCL), *Continue to 2*
❒ High-grade B-cell lymphomas (HGBLs) (also referred to as "double-hit" or "triple-hit" lymphomas), *Continue to 2*

❒ Monomorphic post-transplant lymphoproliferative disorders (B-cell type), *Continue to 2*
❒ Human immunodeficiency virus (HIV)-related B-cell lymphomas (HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, HIV-related plasmablastic lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma), *Continue to 2*

❒ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma (DLBCL), *Continue to 2*

❒ Histologic transformation of indolent lymphomas to high grade B-cell lymphoma, *Continue to 2*

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

2. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 3*
❒ No, *Continue to 5*

3. How many cycles of the requested drug has the patient received?

❒ Less than 6, *Continue to 4*

❒ 6 or more, *Continue to 4*

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?

❒ Diffuse large B-cell lymphoma (DLBCL), *Continue to 6*
❒ High-grade B-cell lymphomas (HGBLs) (also referred to as "double-hit" or "triple-hit" lymphomas), *Continue to 13*

❒ Monomorphic post-transplant lymphoproliferative disorders (B-cell type), *Continue to 20*
❒ Human immunodeficiency virus (HIV)-related B-cell lymphomas (HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, HIV-related plasmablastic lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma), *Continue to 20*

❒ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma (DLBCL), *Continue to 24*

❒ Histologic transformation of indolent lymphomas to high grade B-cell lymphoma, *Continue to 28*

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

❒ First-line treatment, *Continue to 11*

❒ Subsequent treatment, *Continue to 7*

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

❒ Relapsed disease, *Continue to 8*

❒ Refractory disease, *Continue to 8*

❒ Other, please specify. _____, *Continue to 8*

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8. Will the requested drug be used as a bridging option until CAR T-cell product is available?
❒ Yes, *Continue to 10*
❒ No, *Continue to 9*

9. Is the patient a candidate for transplant?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. What is the requested regimen?

❒ The requested drug will be used as a single agent, *Continue to 31*

❒ The requested drug will be used in combination with bendamustine and/or rituximab, *Continue to 31*

❒ Other, please specify. _____, *Continue to 31*

11. Is the International Prognostic Index score greater than 1?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. What is the requested regimen?
❒ The requested drug will be used in combination with a rituximab product, cyclophosphamide, doxorubicin, and prednisone (R-CHP), *Continue to 31*

❒ Other, please specify. _____, *Continue to 31*

13. What is the requested regimen?

❒ The requested drug will be used as a single agent, *Continue to 14*

❒ The requested drug will be used in combination with bendamustine and/or rituximab, *Continue to 14*
❒ The requested drug will be used in combination with a rituximab product, cyclophosphamide, doxorubicin, and prednisone (R-CHP), *Continue to 17*

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

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

❒ First-line treatment, *Continue to 15*

❒ Subsequent treatment, *Continue to 15*

15. Will the requested medication be used as a bridging option until CAR T-cell product is available?
❒ Yes, *Continue to 31*
❒ No, *Continue to 16*

16. Is the patient a candidate for transplant?
❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

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

❒ First-line treatment, *Continue to 18*

❒ Subsequent treatment, *Continue to 18*

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18. Is the International Prognostic Index score greater than 1?

❒ Yes, *Continue to 19*

❒ No, *Continue to 19*

19. Does the patient have MYC and BCL6 without BCL2 rearrangements?

❒ Yes, *Continue to 31*

❒ No, *Continue to 31*

❒ Unknown, *Continue to 31*

20. What is the requested regimen?

❒ The requested drug will be used as a single agent, *Continue to 21*

❒ The requested drug will be used in combination with bendamustine and/or rituximab, *Continue to 21*

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

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

❒ First-line treatment, *Continue to 22*

❒ Subsequent treatment, *Continue to 22*

22. Will the requested medication be used as a bridging option until CAR T-cell product is available?
❒ Yes, *Continue to 31*
❒ No, *Continue to 23*

23. Is the patient a candidate for transplant?
❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

24. What is the requested regimen?

❒ The requested drug will be used as a single agent, *Continue to 25*

❒ The requested drug will be used in combination with bendamustine and/or rituximab, *Continue to 25*
❒ The requested drug will be used in combination with a rituximab product, cyclophosphamide, doxorubicin, and prednisone (R-CHP), *Continue to 27*

❒ Other, please specify. _____, *Continue to 25*

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

❒ First-line treatment, *Continue to 26*

❒ Subsequent treatment, *Continue to 26*

26. Is the patient a candidate for transplant?
❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

27. Is the International Prognostic Index score of 2 or greater?
❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

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28. Does the patient have MYC and BCL6 without BCL2 rearrangements?

❒ Yes, *Continue to 29*

❒ No, *Continue to 29*

❒ Unknown, *Continue to 29*

29. What is the requested regimen?
❒ The requested drug will be used in combination with a rituximab product, cyclophosphamide, doxorubicin, and prednisone (R-CHP), *Continue to 30*

❒ Other, please specify. _____, *Continue to 30*

30. Is the International Prognostic Index score of 2 or greater?
❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

31. How many cycles of chemotherapy containing the requested drug are planned?

❒ More than 6, *No further questions*
❒ 6 or less, *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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