



Poteligeo

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: _____
Patient's ID: _____
Physician's Name: _____
Specialty: _____
Physician Office Telephone: _____

Date: _____
Patient's Date of Birth: _____
NPI#: _____
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:

- | | | |
|--|---------------------------------|---|
| <input type="checkbox"/> Ambulatory Surgical | <input type="checkbox"/> Home | <input type="checkbox"/> Off Campus Outpatient Hospital |
| <input type="checkbox"/> On Campus Outpatient Hospital | <input type="checkbox"/> Office | <input type="checkbox"/> 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. Poteligeo SGM 2652-A – 6/2024.

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?
☐ Mycosis fungoides (MF), *Continue to 2*
☐ Sezary syndrome (SS), *Continue to 2*
☐ Adult T-cell leukemia/lymphoma (ATLL), *Continue to 2*
☐ Other, please specify. _____, *Continue to 2*
2. Is this a request for continuation of therapy with the requested drug?
☐ 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?
☐ Mycosis fungoides (MF), *No further questions*
☐ Sezary syndrome (SS), *No further questions*
☐ Adult T-cell leukemia/lymphoma, *Continue to 5*
5. Will the requested drug be used as a single agent?
☐ Yes, *Continue to 6*
☐ No, *Continue to 6*
6. What is the place in therapy in which the requested drug will be used?
☐ First line therapy, *Continue to 7*
☐ Subsequent therapy, *Continue to 7*
7. What is the patient's adult T-cell leukemia/lymphoma subtype?
☐ Chronic high risk, *No further questions*
☐ Acute, *No further questions*
☐ Lymphoma, *No further questions*
☐ None of the above/unknown, *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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