Proleukin

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

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?

❒ Renal cell carcinoma, *Continue to 3*

❒ Cutaneous melanoma, *Continue to 2*

❒ Chronic graft-versus-host disease (GVHD), *Continue to 3*

❒ Neuroblastoma, *Continue to 3*

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

2. Will the requested drug be used following Amtagvi infusion?

❒ Yes, *Continue to 14*

❒ No, *Continue to 3*

3. Is this a request for continuation of therapy with the requested drug?

❒ Yes, *Continue to 4*

❒ No, *Continue to 12*

4. What is the diagnosis?

❒ Renal cell carcinoma, *Continue to 6*

❒ Cutaneous melanoma, *Continue to 5*

❒ Chronic graft-versus-host disease (GVHD), *Continue to 10*

❒ Neuroblastoma, *Continue to 11*

5. Will the requested drug be used as single agent subsequent treatment?

❒ Yes, *Continue to 6*

❒ No, *Continue to 6*

6. Has the patient been evaluated for response approximately 4 weeks after completion of a course of therapy with the requested drug and will again be evaluated immediately prior to the scheduled start of the next treatment course?

❒ Yes, *Continue to 7*

❒ No, *Continue to 7*

7. Did the patient experience any tumor shrinkage following the last course of therapy with the requested drug?

❒ Yes, *Continue to 8*

❒ No, *Continue to 8*

8. Is retreatment with the requested drug contraindicated for the patient?

❒ Yes, *Continue to 9*

❒ No, *Continue to 9*

9. Will the patient's treatment course with the requested drug be separated by a rest period of at least 7 weeks from the date of hospital discharge?

❒ Yes, *No Further Questions*

❒ No, X

10. Is there improvement in symptoms and no unacceptable toxicity?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

11. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

12. What is the diagnosis?
❒ Renal cell carcinoma, *Continue to 13*
❒ Cutaneous melanoma, *Continue to 16*
❒ Chronic graft-versus-host disease, *Continue to 19*
❒ Neuroblastoma, *No Further Questions*

13. What is the clinical setting in which the requested drug will be used?
❒ Metastatic disease, *No Further Questions*
❒ Other, please specify. _____, *No Further Questions*

14. How many doses of therapy has the patient received with the requested drug following Amtagvi infusion?
_____ doses, *No Further Questions*

15. What is the clinical setting in which the requested drug will be used?
❒ Metastatic disease, *No Further Questions*
❒ Unresectable disease, *No Further Questions*
❒ Other, please specify. _____, *No Further Questions*

16. What is the clinical setting in which the requested drug will be used?
❒ Metastatic disease, *Continue to 17*
❒ Unresectable disease, *Continue to 17*
❒ Other, please specify. _____, *Continue to 17*

17. Will the requested drug be given as high-dose single agent therapy?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. What is the place in therapy in which the requested drug will be used?
❒ First-line treatment, *No Further Questions*
❒ Subsequent treatment, *No Further Questions*

19. Did the patient respond to first-line therapy options?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*
❒ Unknown, *Continue to 20*

20. Is the requested drug being used as additional therapy in conjunction with systemic corticosteroids?
❒ 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)**