Bortezomib, Velcade

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

 Bortezomib-Velcade SGM 2233-C – 04/2025.

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. What is the patient's diagnosis?

❒ Multiple myeloma, *Continue to 2*

❒ Mantle cell lymphoma, *Continue to 2*

❒ Multicentric Castleman disease, *Continue to 2*

❒ Systemic light chain amyloidosis, *Continue to 2*

❒ Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, *Continue to 2*

❒ Adult T-cell leukemia/lymphoma, *Continue to 2*

❒ Antibody mediated rejection of solid organ, *Continue to 2*

❒ Acute lymphoblastic leukemia, *Continue to 2*

❒ Follicular lymphoma, *Continue to 2*

❒ Kaposi sarcoma, *Continue to 2*

❒ Pediatric Classic Hodgkin Lymphoma, *Continue to 2*

❒ POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome, *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, *Continue to 12*

❒ No, *Continue to 12*

4. What is the patient's diagnosis?

❒ Multiple myeloma, *Continue to 12*

❒ Mantle cell lymphoma, *Continue to 12*

❒ Multicentric Castleman disease, *Continue to 5*

❒ Systemic light chain amyloidosis, *Continue to 12*

❒ Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, *Continue to 12*

❒ Adult T-cell leukemia/lymphoma, *Continue to 6*

❒ Antibody mediated rejection of solid organ, *Continue to 12*

❒ Acute lymphoblastic leukemia, *Continue to 12*

❒ Follicular lymphoma, *Continue to 8*

❒ Kaposi sarcoma, *Continue to 9*

❒ Pediatric Classic Hodgkin Lymphoma, *Continue to 10*

❒ POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome, *Continue to 11*

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

❒ First line therapy, *Continue to 12*

❒ Subsequent therapy, *Continue to 12*

6. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. What is the place in therapy in which the requested drug will be used?
❒ First line therapy, *Continue to 12*
❒ Subsequent therapy, *Continue to 12*

8. What is the clinical setting in which the requested drug will be used?
❒ Relapsed disease, *Continue to 12*
❒ Refractory disease, *Continue to 12*
❒ Other, please specify. _____, *Continue to 12*

9. What is the place in therapy in which the requested drug will be used?
❒ First line therapy, *Continue to 12*
❒ Subsequent therapy, *Continue to 12*

10. What is the clinical setting in which the requested drug will be used?
❒ Relapsed disease, *Continue to 12*
❒ Refractory disease, *Continue to 12*
❒ Other, please specify. _____, *Continue to 12*

11. Will the requested drug be used in combination with dexamethasone?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. What is the patient's height in inches? _____ inches, *Continue to 13*

13. What is the patient's weight in pounds? _____ pounds, *Continue to 14*

14. What is the patient's Body Surface Area (BSA)? Note: Average adult BSA is around 1.7 square meters.
_____ m2, *Continue to 15*

15. What is the patient's dose in milligrams? _____ mg, *Continue to 16*

16. Will the patient's dose exceed 1.6 mg per square meter?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Does the patient require more than 7 doses per 30 day period?
❒ 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)**

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