



## Vidaza [azacitidine]

### 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.

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**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**

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**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](http://www.caremark.com)**

**Criteria Questions:**

1. What is the diagnosis?

☐ Myelodysplastic syndrome (MDS), *Continue to 2*

☐ Acute myeloid leukemia (AML), *Continue to 2*

☐ Accelerated phase or blast phase myeloproliferative neoplasm, *Continue to 2*

☐ Blastic plasmacytoid dendritic cell neoplasm (BPDCN), *Continue to 4*

☐ Myelodysplastic syndrome (MDS)/Myeloproliferative Neoplasms (MPN) Overlap Neoplasms (i.e. chronic myelomonocytic leukemia (CMML), juvenile myelomonocytic leukemia (JMML), BCR-ABL negative atypical chronic myeloid leukemia (aCML), MDS/MPN with neutrophilia, unclassifiable MDS/MPN, MDS/MPN not otherwise specified (NOS) or MDS/MPN with ring sideroblasts and thrombocytosis), *Continue to 2*

☐ Peripheral T-Cell Lymphoma (PTCL) [including the following subtypes: angioimmunoblastic T-cell lymphoma (AITL), nodal peripheral T-cell lymphoma with TFH phenotype (PTCL, TFH), follicular T-cell lymphoma (FTCL)], *Continue to 9*

☐ Other, please specify. \_\_\_\_\_, *No further questions*

2. Is the patient currently receiving treatment with the requested medication?

☐ Yes, *Continue to 3*

☐ No, *No Further Questions*

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

☐ Yes, *No Further Questions*

☐ No, *No Further Questions*

4. Is the patient currently receiving treatment with the requested medication?

☐ Yes, *Continue to 5*

☐ No, *Continue to 6*

5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

☐ Yes, *No Further Questions*

☐ No, *No Further Questions*

6. Is the requested drug being used for systemic disease with palliative intent?

☐ Yes, *Continue to 8*

☐ No, *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*

8. Will the requested medication be used in combination with venetoclax (Venclexta)?

☐ Yes, *No Further Questions*

☐ No, *No Further Questions*

9. Is the patient currently receiving treatment with the requested drug?

☐ Yes, *Continue to 10*

☐ No, *Continue to 11*

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10. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

☐ Yes, *No Further Questions*

☐ No, *No Further Questions*

11. 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*

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

☐ Relapsed disease, *Continue to 13*

☐ Refractory disease, *Continue to 13*

☐ Other, please specify. \_\_\_\_\_, *Continue to 13*

13. Will the requested drug be used as a single agent?

☐ 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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