Zynlonta

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

 Zynlonta SGM 4699-A – 12/2024.

Criteria Questions:

1. What is the diagnosis?

❒ HIV-Related B-cell lymphomas (HIV-related diffuse large B-cell lymphoma, primary effusion 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, *Continue to 2*

❒ Large B-cell lymphoma (e.g., diffuse large B-cell lymphoma [DLBCL] not otherwise specified [NOS], DLBCL arising from low grade lymphoma, high-grade B-cell lymphoma), *Continue to 2*

❒ Post-transplant lymphoproliferative disorders (PTLD) (B-cell type), *Continue to 2*

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

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

❒ Yes, *Continue to 3*

❒ No, *Continue to 4*

3. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

4. What is the diagnosis?

❒ HIV-Related B-cell lymphomas (HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma), *Continue to 8*

❒ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, *Continue to 11*

❒ Large B-cell lymphoma (e.g., diffuse large B-cell lymphoma [DLBCL] not otherwise specified [NOS], DLBCL arising from low grade lymphoma, high-grade B-cell lymphoma), *Continue to 5*

❒ Post-transplant lymphoproliferative Disorders (PTLD) (B-cell type), *Continue to 14*

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

❒ Partial response, *Continue to 6*

❒ No response, *Continue to 6*

❒ Relapsed disease, *Continue to 6*

❒ Refractory disease, *Continue to 6*

❒ Progressive disease, *Continue to 6*

❒ Other, please specify. _____, *Continue to 6*

6. Has the patient received two or more prior lines of systemic therapy? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation or claims history supporting previous lines of therapy.

❒ Yes, *Continue to 7*

❒ No, *Continue to 7*

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

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

8. Has the patient received two or more prior lines of systemic therapy? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical records documentation or claims history supporting previous lines of therapy.
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

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

❒ Partial response, *Continue to 10*

❒ Relapsed disease, *Continue to 10*

❒ Refractory disease, *Continue to 10*

❒ Progressive disease, *Continue to 10*

❒ Other, please specify. _____, *Continue to 10*

10. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

❒ Partial response, *Continue to 12*

❒ No response, *Continue to 12*

❒ Progressive disease, *Continue to 12*

❒ Relapsed disease, *Continue to 12*

❒ Other, please specify. _____, *Continue to 12*

12. Has the patient received treatment with an anthracycline-based regimen (e.g., doxorubicin)?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Is the patient a candidate for transplant?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

❒ Partial response, *Continue to 15*

❒ Relapsed disease, *Continue to 15*

❒ Progressive disease, *Continue to 15*

❒ Refractory disease, *Continue to 15*

❒ Other, please specify. _____, *Continue to 15*

15. Has the patient received two or more lines of systemic therapy? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation or claims history supporting previous lines of therapy.
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. 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)**

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
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