Bendamustine-Treanda-Bendeka-Belrapzo-Vivimusta

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

 Bendamustine-Treanda-Bendeka-Belrapzo-Vivimusta SGM – 07/2024.

Criteria Questions:

1. What is the diagnosis?

❒ Follicular lymphoma, *Continue to 2*
❒ Chronic lymphocytic leukemia (CLL) without chromosome 17p deletion or without TP53 mutation, *Continue to 2*
❒ Small lymphocytic lymphoma (SLL) without chromosome 17p deletion or without TP53 mutation, *Continue to 2*
❒ Diffuse large B-cell lymphoma (DLBCL), *Continue to 2*
❒ Adult T-cell leukemia/lymphoma (ATLL), *Continue to 2*
❒ HIV-related B-cell lymphoma (HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma, plasmablastic lymphoma), *Continue to 2*
❒ Marginal zone lymphoma [nodal, gastric MALT (extranodal marginal zone lymphoma of the stomach), non-gastric MALT (nongastric extranodal marginal zone lymphoma), splenic], *Continue to 2*
❒ Mantle cell lymphoma (MCL), *Continue to 2*
❒ Peripheral T-cell Lymphoma (PTCL) [including the following subtypes: anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with TFH phenotype, or follicular T-cell lymphoma], *Continue to 2*
❒ Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma/Bing-Neel syndrome, *Continue to 2*
❒ Multiple myeloma, *Continue to 2*
❒ Classical Hodgkin lymphoma (cHL), *Continue to 2*
❒ Post-transplant lymphoproliferative disorders, *Continue to 2*
❒ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, *Continue to 2*
❒ High grade B-cell lymphoma, *Continue to 2*
❒ Hepatosplenic T-Cell Lymphoma, *Continue to 2*
❒ Breast implant associated anaplastic large cell lymphoma (ALCL), *Continue to 2*
❒ Systemic light chain amyloidosis, *Continue to 2*
❒ Nodular lymphocyte predominant Hodgkin lymphoma (NLPHL), *Continue to 2*
❒ Hematopoietic cell transplantation, *Continue to 2*
❒ Cold agglutinin disease, *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?

❒ Follicular lymphoma, *No further questions*
❒ Chronic lymphocytic leukemia (CLL) without chromosome 17p deletion or without TP53 mutation, *No further questions*

❒ Small lymphocytic lymphoma (SLL) without chromosome 17p deletion or without TP53 mutation, *No further questions*

❒ Diffuse large B-cell lymphoma (DLBCL), *Continue to 5*

❒ Adult T-cell leukemia/lymphoma (ATLL), *Continue to 12*

❒ HIV-related B-cell lymphoma (HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma, plasmablastic lymphoma), *Continue to 5*

❒ Marginal zone lymphoma [nodal, gastric MALT (extranodal marginal zone lymphoma of the stomach), non-gastric MALT (nongastric extranodal marginal zone lymphoma), splenic], *Continue to 14*

❒ Mantle cell lymphoma (MCL), *Continue to 16*

❒ Peripheral T-cell Lymphoma (PTCL) [including the following subtypes: anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with TFH phenotype, or follicular T-cell lymphoma], *Continue to 17*

❒ Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma/Bing-Neel syndrome, *Continue to 15*

❒ Multiple myeloma, *Continue to 22*

❒ Classical Hodgkin lymphoma (cHL), *Continue to 25*

❒ Post-transplant lymphoproliferative disorders, *Continue to 5*

❒ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, *Continue to 9*

❒ High grade B-cell lymphoma, *Continue to 5*

❒ Hepatosplenic T-Cell Lymphoma, *Continue to 19*

❒ Breast implant associated anaplastic large cell lymphoma (ALCL), *Continue to 27*

❒ Systemic light chain amyloidosis, *Continue to 31*

❒ Nodular lymphocyte predominant Hodgkin lymphoma (NLPHL), *Continue to 29*

❒ Hematopoietic cell transplantation, *Continue to 33*

❒ Cold agglutinin disease, *Continue to 35*

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

❒ First-line therapy, *Continue to 6*

❒ Subsequent therapy, *Continue to 6*

6. Will the requested drug be used as a bridging option until CAR T-cell product is available?

❒ Yes, *Continue to 8*

❒ No, *Continue to 7*

7. Is the patient a candidate for transplant?

❒ Yes, *Continue to 8*

❒ No, *Continue to 8*

8. What is the requested regimen?

❒ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy), *No further questions*

❒ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy) and rituximab, *No further questions*

❒ Other, please specify. _____, *No further questions*

9. What is the requested regimen?

❒ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy), *Continue to 10*
❒ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy) and rituximab, *Continue to 10*
❒ Other, please specify. _____, *Continue to 10*

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

❒ First-line therapy, *Continue to 11*
❒ Subsequent therapy, *Continue to 11*

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

12. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

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

❒ First-line therapy, *No further questions*
❒ Subsequent therapy, *No further questions*

14. What is the requested regimen?

❒ The requested drug will be used in combination with rituximab, *No further questions*
❒ The requested drug will be used in combination with obinutuzumab (Gazyva), *No further questions*
❒ Other, please specify. _____, *No further questions*

15. What is the requested regimen?

❒ The requested drug will be used a single agent, *No further questions*
❒ The requested drug will be used in combination with rituximab, *No further questions*
❒ Other, please specify. _____, *No further questions*

16. What is the requested regimen?

❒ The requested drug will be used in combination with rituximab, *No further questions*
❒ The requested drug will be used as a component of RBAC500 (rituximab, bendamustine, and cytarabine), *No further questions*
❒ Other, please specify. _____, *No further questions*

17. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Will the requested drug be used as palliative or subsequent therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

19. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

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

❒ Refractory disease, *Continue to 21*

❒ Other, please specify. _____, *Continue to 21*

21. Has the patient received TWO first-line therapy regimens?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

22. What is the requested regimen?

❒ The requested drug will be used as a single agent, *Continue to 23*
❒ The requested drug will be used in combination with lenalidomide (Revlimid) and dexamethasone, *Continue to 23*
❒ The requested drug will be used in combination with bortezomib (Velcade) and dexamethasone, *Continue to 23*

❒ The requested drug will be used in combination with carfilzomib and dexamethasone, *Continue to 23*

❒ Other, please specify. _____, *Continue to 23*

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

❒ Relapsed disease, *Continue to 24*

❒ Progressive disease, *Continue to 24*

❒ Other, please specify. _____, *Continue to 24*

24. Has the patient tried more than 3 prior therapies?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

25. What is the requested regimen?

❒ The requested drug will be used as a single agent, *Continue to 26*

❒ The requested drug will be used in combination with brentuximab vedotin (Adcetris), *Continue to 26*

❒ The requested drug will be used in combination with gemcitabine and vinorelbine, *Continue to 26*

❒ The requested drug will be used in combination with carboplatin and etoposide, *Continue to 26*

❒ Other, please specify. _____, *Continue to 26*

26. Will the requested drug be used as subsequent therapy or palliative therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

27. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

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

❒ First-line therapy, *No further questions*

❒ Subsequent therapy, *No further questions*

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

❒ First-line therapy, *Continue to 30*

❒ Subsequent therapy, *Continue to 30*

30. Will the requested drug be used in combination with rituximab?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

31. Will the requested drug be used in combination with dexamethasone?
❒ Yes, *Continue to 32*
❒ No, *Continue to 32*

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

❒ Relapsed disease, *No further questions*

❒ Refractory disease, *No further questions*

❒ Other, please specify. _____, *No further questions*

33. Will the requested drug be used as conditioning for autologous transplant?
❒ Yes, *Continue to 34*
❒ No, *Continue to 34*

34. Will the requested drug be used in combination with etoposide, cytarabine and melphalan?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

35. Will the requested drug be used in combination with rituximab?
❒ 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)**