PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 3/31/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:** _____
Specialty: _____
Physician Office Address: _____ **Physician Office Telephone:** _____

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Mantle cell lymphoma (If checked, go to 2) ☐
   - Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL) (If checked, go to 8) ☐
   - Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma (If checked, go to 10) ☐
   - Gastric mucosa-associated lymphoid tissue (MALT) Lymphoma (extranodal marginal zone lymphoma of the stomach) (If checked, go to 13) ☐
   - Non-Gastric MALT Lymphoma (extranodal marginal zone lymphoma of nongastric sites) (If checked, go to 13) ☐
   - Nodal Marginal Zone Lymphoma (If checked, go to 13) ☐
   - Splenic Marginal Zone Lymphoma (If checked, go to 13) ☐
   - Other, please specify. (If checked, no further questions) ☐

     _____

2. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

3. How will the requested medication be used?
   - Single agent (If checked, go to 4) ☐
   - In combination with rituximab (If checked, go to 5) ☐
   - In combination with bendamustine and rituximab (If checked, go to 6) ☐
   - Other, please specify. (If checked, no further questions) ☐

     _____

4. What is the place in therapy in which the requested medication will be used?
   - First-line treatment (If checked, no further questions) ☐
   - Subsequent treatment (If checked, no further questions) ☐

5. What is the place in therapy in which the requested medication will be used?
   - Induction therapy (If checked, no further questions) ☐

Pre-treatment to limit the number of cycles of induction therapy with RHyperCVAD (rituximab, cyclophosphamide, vincristine, doxorubicin and dexamethasone) regimen (If checked, no further questions) ☐

Other, please specify. (If checked, no further questions) ☐

_____

6. Has the patient been previously treated for mantle cell lymphoma? **Y** ☐ **N** ☐

7. Is the patient transplant eligible? **Y** ☐ **N** ☐

8. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

9. What is the requested regimen?

   Single agent (If checked, no further questions) ☐

   In combination with obinutuzumab (Gazyva) (If checked, no further questions) ☐

   Other, please specify. (If checked, no further questions) ☐

   _____

10. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

11. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

12. What is the place in therapy in which the requested medication will be used?

   First-line therapy (If checked, no further questions) ☐

   Subsequent therapy (If checked, no further questions) ☐

13. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

14. What is the place in therapy in which the requested medication will be used?

   First-line therapy (If checked, no further questions) ☐

   Subsequent therapy (If checked, no further questions) ☐

15. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date