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:** 9/6/2024
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
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?
   - Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) (If checked, go to 2) ☐
   - T-Cell lymphomas (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
2. Is this a request for continuation of therapy with the requested medication? **Y** ☐ **N** ☐
3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐
4. What is the diagnosis?
   - Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) (If checked, go to 5) ☐
   - T-Cell lymphomas (If checked, go to 7) ☐
5. What is the clinical setting in which the requested medication will be used?
   - Relapsed disease (If checked, go to 6) ☐
   - Refractory disease (If checked, go to 6) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
6. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐
7. Will the requested medication be used to treat one of the following subtypes?
   - Breast implant-associated anaplastic large cell lymphoma (ALCL) (If checked, go to 8) ☐
   - Hepatosplenic T-Cell lymphoma (If checked, go to 11) ☐

Peripheral T-cell lymphoma (PTCL) [including the following subtypes: peripheral T-cell lymphoma not otherwise specified, enteropathy-associated T-cell lymphoma (EATL), monomorphic epitheliotropic intestinal T-cell lymphoma (MEITL), angioimmunoblastic T-cell lymphoma (AITL), nodal peripheral T-cell lymphoma with TFH phenotype (PTCL, TFH), follicular T-cell lymphoma, or anaplastic large cell lymphoma (ALCL)] (If checked, go to 13) ☐

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

_____

8. What is the clinical setting in which the requested medication will be used?

Relapsed disease (If checked, go to 9) ☐

Refractory disease (If checked, go to 9) ☐

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

_____

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

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

Subsequent therapy (If checked, go to 10) ☐

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

11. Will the requested medication be used for refractory disease after 2 first-line regimens? **Y** ☐ **N** ☐

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

13. What is the clinical setting in which the requested medication be used?

Palliative therapy (If checked, go to 15) ☐

Subsequent therapy (If checked, go to 14) ☐

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

_____

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

Relapsed disease (If checked, go to 15) ☐

Refractory disease (If checked, go to 15) ☐

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

_____

15. Will the requested medication be used as a single agent? **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