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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:** 7/17/2024
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 patient's diagnosis?
 - Acute myeloid leukemia (AML) (If checked, go to 2) ☐
 - Other, please specify. (If checked, no further questions) ☐
2. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐
3. Is there evidence of an unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐
4. Does the patient have acute myeloid leukemia with a susceptible isocitrate dehydrogenase-2 (IDH2) mutation? ACTION REQUIRED: If Yes, attach chart note(s) or test results of isocitrate dehydrogenase-2 (IDH2) mutation.
 - Yes (If checked, go to 5) ☐
 - No (If checked, no further questions) ☐
 - Unknown (If checked, no further questions) ☐
 - ACTION REQUIRED: Submit supporting documentation
5. What is the clinical setting in which the requested medication will be administered?
 - Newly diagnosed acute myeloid leukemia (If checked, go to 6) ☐
 - Post-induction therapy for acute myeloid leukemia (If checked, go to 8) ☐
 - Relapsed acute myeloid leukemia (If checked, no further questions) ☐
 - Refractory acute myeloid leukemia (If checked, no further questions) ☐
 - Other, please specify. (If checked, no further questions) ☐
6. Is the patient a candidate for intensive therapy? **Y** ☐ **N** ☐
7. How will the requested medication be used?
 - As a single agent (If checked, no further questions) ☐
 - In combination with azacitidine (If checked, no further questions) ☐

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

☐

8. Has the patient experienced a response to therapy with the requested medication?

Y

☐

N

☐

9. 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

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.