PA Request Criteria

00-000000000

212996

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:** 10/10/2024
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?

Myelofibrosis (If checked, go to 2)	☐
Accelerated/Blast phase myeloproliferative neoplasms (If checked, go to 2)	☐
Polycythemia Vera (If checked, go to 2)	☐
Acute graft-versus-host disease (aGVHD) (If checked, go to 2)	☐
Chronic graft-versus-host disease (cGVHD) (If checked, go to 2)	☐
Ph-like B-cell acute lymphoblastic leukemia (ALL)/Lymphoblastic Lymphoma (LL) (If checked, go to 4)	☐
Chronic myelomonocytic leukemia (CMML)-2 (If checked, go to 4)	☐
T-Cell Large Granular Lymphocytic Leukemia or T-Cell Prolymphocytic Leukemia (If checked, go to 4)	☐
BCR-ABL negative atypical chronic myeloid leukemia (aCML)/Myelodysplastic/Myeloproliferative Neoplasms (MDS/MPN) with Neutrophilia (If checked, go to 4)	☐
Essential thrombocythemia (If checked, go to 2)	☐
Myeloid/Lymphoid neoplasms with eosinophilia (If checked, go to 4)	☐
Chimeric antigen receptor (CAR) T-cell induced cytokine release syndrome (CRS) (If checked, go to 21)	☐
Concomitant myositis and myocarditis (If checked, go to 22)	☐
Other, please specify. (If checked, no further questions)	☐

_____

2.	Is this a request for continuation of therapy with the requested drug?	**Y** ☐	**N** ☐
3.	Has there been an improvement in symptoms without any evidence of unacceptable toxicity while on the current regimen?	**Y** ☐	**N** ☐
4.	Is this a request for continuation of therapy with the requested drug?	**Y** ☐	**N** ☐
5.	Is there evidence of unacceptable toxicity or disease progression while on the current regimen?	**Y** ☐	**N** ☐

6. What is the patient's diagnosis?

- Myelofibrosis (If checked, no further questions) ☐
- Accelerated/Blast phase myeloproliferative neoplasms (If checked, go to 7) ☐
- Polycythemia Vera (If checked, go to 8) ☐
- Acute graft-versus-host disease (aGVHD) (If checked, go to 19) ☐
- Chronic graft versus host-disease (cGVHD) (If checked, go to 20) ☐
- Ph-like B-cell acute lymphoblastic leukemia (ALL)/Lymphoblastic Lymphoma (LL) (If checked, go to 10) ☐
- Chronic myelomonocytic leukemia (CMML)-2 (If checked, go to 11) ☐
- T-Cell Large Granular Lymphocytic Leukemia (If checked, go to 13) ☐
- T-Cell prolymphocytic leukemia (If checked, go to 12) ☐
- BCR-ABL negative atypical chronic myeloid leukemia (aCML)/Myelodysplastic/Myeloproliferative Neoplasms (MDS/MPN) with Neutrophilia (If checked, go to 15) ☐
- Essential thrombocythemia (If checked, go to 16) ☐
- Myeloid/Lymphoid neoplasms with eosinophilia (If checked, go to 17) ☐
- Concomitant myositis and myocarditis (If checked, go to 22) ☐
- Chimeric antigen receptor (CAR) T-cell induced cytokine release syndrome (CRS) (If checked, go to 21) ☐

7. How will the requested drug be used?

- As a single agent (If checked, no further questions) ☐
- In combination with azacitidine or decitabine (If checked, no further questions) ☐
- Other, please specify. (If checked, no further questions) ☐

_____

8. Did the patient have an inadequate response or intolerance to at least one of the following treatments?

- Yes - hydroxyurea (If checked, no further questions) ☐
- Yes - peginterferon alfa-2a (If checked, no further questions) ☐
- No (If checked, go to 9) ☐

9. Does the patient have high risk disease? **Y** ☐ **N** ☐

10. Does the patient have either of the following mutations? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming either a cytokine receptor-like factor 2 (CRLF2) mutation or a mutation associated with activation of the Janus kinase/signal transducers and activators of transcription (JAK/STAT) pathway.

- Yes - Cytokine receptor-like factor 2 (CRLF2) mutation (If checked, no further questions) ☐
- Yes - A mutation associated with activation of the Janus kinase/signal transducers and activators of transcription (JAK/STAT) pathway (If checked, no further questions) ☐
- No/unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

11. Will the requested drug be used in combination with a hypomethylating agent? **Y** ☐ **N** ☐

12. Will the requested drug be used to treat symptomatic T-cell prolymphocytic leukemia? **Y** ☐ **N** ☐

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

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

Subsequent treatment (If checked, go to 14) ☐

14. Will the requested drug be used as a single agent? **Y** ☐ **N** ☐

15. What is the requested regimen?

The requested medication as a single agent (If checked, no further questions) ☐

The requested medication in combination with a hypomethylating agent (If checked, no further questions) ☐

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

_____

16. Did the patient have an inadequate response or loss of response to at least one of the following treatments?

Yes - hydroxyurea (If checked, no further questions) ☐

Yes - peginterferon alfa-2a (If checked, no further questions) ☐

Yes - anagrelide (If checked, no further questions) ☐

No (If checked, no further questions) ☐

17. Is the disease in chronic phase or blast phase? **Y** ☐ **N** ☐

18. Does testing or analysis confirm JAK2 rearrangement? ACTION REQUIRED: If Yes, attach chart note(s) or test results of JAK2 rearrangement as confirmed by testing or analysis.

Yes (If checked, no further questions) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

19. Does the patient have steroid-refractory acute graft-versus-host disease? **Y** ☐ **N** ☐

20. Has the patient failed at least one prior line of systemic therapy? **Y** ☐ **N** ☐

21. Is the cytokine release syndrome refractory to high-dose corticosteroids and anti-interleukin-6 (anti-IL-6) therapy? **Y** ☐ **N** ☐

22. Is the requested drug being used to treat immune checkpoint inhibitor-related concomitant myositis and myocarditis? **Y** ☐ **N** ☐

23. Will the requested drug be used in combination with abatacept? **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