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:** 6/13/2025
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?
   - Multiple myeloma (If checked, go to 2) ☐
   - Systemic light chain amyloidosis (If checked, go to 2) ☐
   - Waldenstrom macroglobulinemia/lymphoplasmacystic lymphoma (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

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2. Is this a request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐

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

4. What is the patient's diagnosis?
   - Multiple myeloma (If checked, go to 5) ☐
   - Systemic light chain amyloidosis (If checked, go to 16) ☐
   - Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma (If checked, go to 18) ☐

5. What is the prescribed regimen?
   - The requested drug with lenalidomide and dexamethasone (If checked, go to 6) ☐
   - The requested drug with dexamethasone and pomalidomide (If checked, go to 7) ☐
   - The requested drug with cyclophosphamide and dexamethasone (If checked, go to 9) ☐
   - The requested drug with venetoclax and dexamethasone (If checked, go to 10) ☐
   - The requested drug is being prescribed as a substitute for bortezomib or carfilzomib (If checked, go to 12) ☐
   - Other, please specify. (If checked, no further questions) ☐

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6. Has the patient received at least one prior therapy? **Y** ☐ **N** ☐

7. Is the disease lenalidomide- or anti-CD-38 (e.g., Darzalex, Sarclisa) refractory? **Y** ☐ **N** ☐

8. Has the patient received at least 2 prior therapies, including an immunomodulatory agent (e.g., Revlimid) and a proteasome inhibitor (e.g., Velcade)? **Y** ☐ **N** ☐

9. Has the patient received at least one prior therapy? **Y** ☐ **N** ☐

10. Does the patient have a documented t(11:14) translocation? ACTION REQUIRED: If Yes, attach chart note(s) or test results of t(11:14) translocation.

- Yes (If checked, go to 11) ☐
- No (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

11. Has the patient received at least one prior therapy? **Y** ☐ **N** ☐

12. Will the requested drug be used as primary treatment? **Y** ☐ **N** ☐

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

- Relapsed disease (If checked, go to 14) ☐
- Other, please specify. (If checked, no further questions) ☐

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

15. Has the patient been previously treated with the requested drug for primary induction therapy? **Y** ☐ **N** ☐

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

- Relapsed disease (If checked, go to 17) ☐
- Refractory disease (If checked, go to 17) ☐
- Other, please specify. (If checked, no further questions) ☐

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17. What is the requested regimen?

- The requested drug in combination with dexamethasone (If checked, no further questions) ☐
- The requested drug in combination with lenalidomide and dexamethasone (If checked, no further questions) ☐
- The requested drug in combination with cyclophosphamide and dexamethasone (If checked, no further questions) ☐
- Other, please specify. (If checked, no further questions) ☐

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18. Will the requested drug be prescribed in combination with rituximab and dexamethasone? **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