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:** 7/18/2024
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
_____ **NPI#:** **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?
   - Acute Myeloid Leukemia (AML) (If checked, go to 2) ☐
   - Peripheral T-Cell Lymphoma (PTCL) [including the following subtypes: angioimmunoblastic T-cell lymphoma (AITL), nodal peripheral T-cell lymphoma with TFH phenotype (PTCL, TFH), follicular T-cell lymphoma (FTCL)] (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 unacceptable toxicity or disease progression on the current regimen? **Y** ☐ **N** ☐

4. What is the diagnosis?
   - Acute Myeloid Leukemia (AML) (If checked, go to 5) ☐
   - Peripheral T-Cell Lymphoma (PTCL) [including the following subtypes: angioimmunoblastic T-cell lymphoma (AITL), nodal peripheral T-cell lymphoma with TFH phenotype (PTCL, TFH), follicular T-cell lymphoma (FTCL)] (If checked, go to 7) ☐

5. Has the patient achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy? **Y** ☐ **N** ☐

6. Is the patient able to complete intensive curative therapy? **Y** ☐ **N** ☐

7. 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, go to 8) ☐

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. Is the requested medication being 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

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