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) ☐
   - Kaposi sarcoma (If checked, go to 2) ☐
   - Primary central nervous system lymphoma (If checked, go to 2) ☐
   - POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome (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 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 13) ☐
   - Kaposi sarcoma (If checked, go to 15) ☐
   - Primary central nervous system lymphoma (If checked, go to 18) ☐
   - POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome (If checked, go to 19) ☐

5. What is the prescribed regimen?
   - The requested drug in combination with elotuzumab and dexamethasone (If checked, go to 9) ☐
   - The requested drug in combination with ixazomib and dexamethasone (If checked, go to 7) ☐
   - The requested drug in combination with bortezomib and dexamethasone (If checked, go to 6) ☐

The requested drug in combination with cyclophosphamide and dexamethasone (If checked, go to 9) ☐

The requested drug in combination with isatuximab-irfc and dexamethasone (If checked, go to 8) ☐

The requested drug in combination with dexamethasone (If checked, go to 9) ☐

The requested drug in combination with selinexor and dexamethasone (If checked, go to 9) ☐

The requested drug as a single agent (If checked, go to 9) ☐

The requested drug in combination with daratumumab and dexamethasone (If checked, go to 10) ☐

The requested drug in combination with carfilzomib and dexamethasone (If checked, go to 12) ☐

The requested drug in combination with carfilzomib, daratumumab, and dexamethasone (If checked, go to 12) ☐

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

_____

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

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

8. Is the disease bortezomib- or lenalidomide-refractory? **Y** ☐ **N** ☐

9. Has the patient previously received at least two prior regimens including an immunomodulatory agent (e.g., Revlimid) and a proteasome inhibitor (e.g., Velcade) as treatment for multiple myeloma? **Y** ☐ **N** ☐

10. Has the patient previously received an immunomodulatory agent (e.g., Revlimid) and a proteasome inhibitor (e.g., Velcade) for multiple myeloma? **Y** ☐ **N** ☐

11. Is the disease bortezomib- or lenalidomide-refractory? **Y** ☐ **N** ☐

12. Has the patient previously received at least one prior regimen for the treatment of multiple myeloma? **Y** ☐ **N** ☐

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

Relapsed disease (If checked, go to 14) ☐

Refractory disease (If checked, go to 14) ☐

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

_____

14. Will the requested drug be used in combination with dexamethasone? **Y** ☐ **N** ☐

15. Is the patient HIV-negative? **Y** ☐ **N** ☐

16. Does the patient have a diagnosis of HIV-related Kaposi sarcoma? **Y** ☐ **N** ☐

17. Will the requested drug be used in combination with antiretroviral therapy? **Y** ☐ **N** ☐

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

19. Will the requested drug be used in combination with 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**

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