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: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:**
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 patient's diagnosis?

- Multiple myeloma (If checked, go to 2) ☐
- T-cell lymphomas (including peripheral T-cell lymphomas not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with TFH phenotype, follicular T-cell lymphoma, adult T-cell leukemia/lymphoma, hepatosplenic T-cell lymphoma) (If checked, go to 2) ☐
- Primary central nervous system (CNS) lymphoma (If checked, go to 2) ☐
- Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) (If checked, go to 2) ☐
- B-Cell lymphomas (including HIV-related B-cell lymphomas [non-germinal center diffuse large B-cell lymphoma, HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, HHV8+ diffuse large B-cell lymphoma, HIV-related plasmablastic lymphoma], monomorphic post-transplant lymphoproliferative disorder, diffuse large B-cell lymphoma, follicular lymphoma, marginal zone lymphoma: Extranodal [nongastric/gastric mucosa-associated lymphoid tissue {MALT}], splenic or nodal marginal zone lymphoma, high-grade B-cell lymphomas, histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, mantle cell lymphoma) (If checked, go to 2) ☐
- Multicentric Castleman disease (If checked, go to 2) ☐
- Myelodysplastic syndrome (If checked, go to 2) ☐
- Systemic light chain amyloidosis (If checked, go to 2) ☐
- Classic Hodgkin lymphoma (If checked, go to 2) ☐
- POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome (If checked, go to 2) ☐
- Myelodysplastic syndrome/myeloproliferative neoplasms (If checked, go to 2) ☐
- Kaposi Sarcoma (If checked, go to 2) ☐
- Smoldering Myeloma (If checked, go to 2) ☐
- Histiocytic Neoplasms (including Langerhans cell histiocytosis and Rosai Dorfman disease) (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 medication? **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, no further questions) ☐
- T-cell lymphomas (including peripheral T-cell lymphomas not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with TFH phenotype, follicular T-cell lymphoma, adult T-cell leukemia/lymphoma, hepatosplenic T-cell lymphoma) (If checked, go to 5) ☐
- Primary central nervous system (CNS) lymphoma (If checked, go to 9) ☐
- Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) (If checked, go to 11) ☐
- B-Cell lymphomas (including HIV-related B-cell lymphomas [non-germinal center diffuse large B-cell lymphoma, HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, HHV8+ diffuse large B-cell lymphoma, HIV-related plasmablastic lymphoma], monomorphic post-transplant lymphoproliferative disorder, diffuse large B-cell lymphoma, follicular lymphoma, marginal zone lymphoma: Extranodal [nongastric/gastric mucosa-associated lymphoid tissue {MALT}], splenic or nodal marginal zone lymphoma, high-grade B-cell lymphomas, histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, mantle cell lymphoma) (If checked, go to 12) ☐
- Multicentric Castleman disease (If checked, go to 16) ☐
- Myelodysplastic syndrome (If checked, go to 17) ☐
- Systemic light chain amyloidosis (If checked, no further questions) ☐
- Classic Hodgkin lymphoma (If checked, go to 19) ☐
- POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome (If checked, go to 21) ☐
- Myelodysplastic/myeloproliferative neoplasms (If checked, go to 24) ☐
- Kaposi Sarcoma (If checked, go to 25) ☐
- Smoldering Myeloma (If checked, go to 26) ☐
- Histiocytic Neoplasms (including Langerhans cell histiocytosis and Rosai Dorfman disease) (If checked, go to 27) ☐

5. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

6. Which of the following T-cell lymphoma subtypes does the patient have?

- Peripheral T-cell lymphoma not otherwise specified (If checked, go to 7) ☐
- Angioimmunoblastic T-cell lymphoma (If checked, go to 7) ☐
- Enteropathy-associated T-cell lymphoma (If checked, go to 7) ☐
- Monomorphic epitheliotropic intestinal T-cell lymphoma (If checked, go to 7) ☐
- Nodal peripheral T-cell lymphoma with TFH phenotype (If checked, go to 7) ☐
- Follicular T-cell lymphoma (If checked, go to 7) ☐
- Adult T-cell leukemia/lymphoma (If checked, go to 8) ☐
- Hepatosplenic T-cell lymphoma (If checked, go to 8) ☐
- Other, please specify. (If checked, no further questions) ☐

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7. What is the place in therapy in which the requested medication will be used?

- Subsequent treatment (If checked, no further questions) ☐

Initial palliative therapy (If checked, no further questions) ☐

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

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8. What is the place in therapy in which the requested medication will be used?

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

Subsequent treatment (If checked, no further questions) ☐

9. Has the patient received prior therapy with Bruton Tyrosine Kinase inhibitor (e.g., Brukinsa, Calquence) and venetoclax- based regimens? **Y** ☐ **N** ☐

10. What is the requested regimen?

Single agent (If checked, no further questions) ☐

In combination with rituximab (If checked, no further questions) ☐

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

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11. What is the requested regimen?

Single agent (If checked, no further questions) ☐

In combination with rituximab (If checked, no further questions) ☐

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

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12. Which of the following B-cell lymphoma subtypes does the patient have?

HIV-related B-cell lymphomas, including non-germinal center diffuse large B-cell lymphoma, HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, HHV8+ diffuse large B-cell lymphoma, or HIV-related plasmablastic lymphoma (If checked, go to 13) ☐

Monomorphic post-transplant lymphoproliferative disorder (If checked, go to 16) ☐

Diffuse large B-cell lymphoma (If checked, go to 16) ☐

Follicular lymphoma (If checked, no further questions) ☐

Marginal zone lymphomas, including nongastric/gastric mucosa-associated lymphoid tissue lymphoma and splenic/nodal marginal zone lymphoma (If checked, go to 14) ☐

High-grade B-cell lymphomas (If checked, go to 16) ☐

Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma (If checked, go to 16) ☐

Mantle cell lymphoma (If checked, no further questions) ☐

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

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

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

Subsequent treatment (If checked, no further questions) ☐

14. What is the marginal zone lymphoma subtype?

Extranodal (nongastric/gastric mucosa-associated lymphoid tissue (MALT)) (If checked, go to 15) ☐

Splenic or nodal marginal zone lymphoma (If checked, go to 15) ☐

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

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15. What is the place in therapy in which the requested medication will be used?

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

Subsequent treatment (If checked, no further questions) ☐

16. What is the place in therapy in which the requested medication will be used?

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

Subsequent treatment (If checked, no further questions) ☐

17. Does the patient have lower risk myelodysplastic syndrome (defined as Revised International Prognostic Scoring System (IPSS-R) (Very Low, Low, Intermediate), International Prognostic Scoring System (IPSS) (Low/Intermediate-1), WHO classification-based Prognostic Scoring System (WPSS) (Very Low, Low, Intermediate))? **Y** ☐ **N** ☐

18. Prior to starting therapy with the requested medication, does the patient have symptomatic anemia? **Y** ☐ **N** ☐

19. Is the disease refractory to at least 3 prior lines of therapy? **Y** ☐ **N** ☐

20. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

21. What is the requested regimen?

In combination with dexamethasone (If checked, no further questions) ☐

In combination with dexamethasone and daratumumab (If checked, go to 22) ☐

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

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22. Will the requested medication be used as induction therapy? **Y** ☐ **N** ☐

23. Is the patient a transplant candidate? **Y** ☐ **N** ☐

24. What is the requested regimen?

Single agent (If checked, no further questions) ☐

In combination with a hypomethylating agent (If checked, no further questions) ☐

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

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25. What is the place in therapy in which the requested medication will be used?

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

Subsequent treatment (If checked, no further questions) ☐

26. Will the requested medication be used for treatment of asymptomatic high-risk disease? **Y** ☐ **N** ☐

27. 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.

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Prescriber (Or Authorized) Signature and Date