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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:** 2/20/2026
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 diagnosis?
 - Acute leukemia (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 while on the current regimen? **Y** **N**

4. What is the clinical setting in which the requested medication will be used?
 - Relapsed disease (If checked, go to 5)
 - Refractory disease (If checked, go to 5)
 - Other, please specify. (If checked, no further questions)
 - _____

5. Is the patient's disease positive for a lysine methyltransferase 2A gene (KMT2A) translocation? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming KMT2A translocation status.
 - Yes (If checked, no further questions)
 - No (If checked, no further questions)
 - Unknown (If checked, no further questions)
 - ACTION REQUIRED: Submit supporting documentation

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

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.