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 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?
   - Epithelioid sarcoma (If checked, go to 2) ☐
   - Follicular lymphoma (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 medication? **Y** ☐ **N** ☐

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

4. Is there evidence of disease progression while on the current regimen? **Y** ☐ **N** ☐

5. What is the patient's diagnosis?
   - Epithelioid sarcoma (If checked, go to 6) ☐
   - Follicular lymphoma (If checked, go to 10) ☐

6. What is the clinical setting in which the requested medication will be used?
   - Metastatic disease (If checked, go to 7) ☐
   - Locally advanced disease (If checked, go to 7) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

7. Is the disease eligible for complete resection? **Y** ☐ **N** ☐

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

9. What is the patient's age in years?
   - Less than 16 years old (If checked, no further questions) ☐
   - Greater than or equal to 16 years old (If checked, no further questions) ☐

10. What is the clinical setting in which the requested medication will be used?

- Relapsed disease (If checked, go to 11) ☐
- Refractory disease (If checked, go to 11) ☐
- Other, please specify. (If checked, no further questions) ☐

_____

11. Has the patient received at least 2 prior therapies for follicular lymphoma? **Y** ☐ **N** ☐

12. Are there satisfactory alternative treatment options available for the patient's disease? **Y** ☐ **N** ☐

13. What is the patient's age in years?

- Less than 18 years old (If checked, no further questions) ☐
- Greater than or equal to 18 years old (If checked, no further questions) ☐

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