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?
   - Myelodysplastic syndrome (MDS) (If checked, go to 2) ☐
   - Acute myeloid leukemia (AML) (If checked, go to 2) ☐
   - Accelerated phase or blast phase myeloproliferative neoplasm (If checked, go to 2) ☐
   - Blastic plasmacytoid dendritic cell neoplasm (BPDCN) (If checked, go to 2) ☐
   - Myelodysplastic syndrome (MDS)/Myeloproliferative Neoplasms (MPN) Overlap Neoplasms (i.e. chronic myelomonocytic leukemia (CMML), juvenile myelomonocytic leukemia (JMML), BCR-ABL negative atypical chronic myeloid leukemia (aCML), MDS/MPN with neutrophilia, unclassifiable MDS/MPN, MDS/MPN not otherwise specified (NOS), MDS/MPN with ring sideroblasts and thrombocytosis (If checked, go to 2) ☐
   - MDS/MPN with SF3B1 mutation (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 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 diagnosis?
   - Myelodysplastic syndrome (MDS) (If checked, no further questions) ☐
   - Acute myeloid leukemia (AML) (If checked, no further questions) ☐
   - Accelerated phase or blast phase myeloproliferative neoplasm (If checked, no further questions) ☐
   - Blastic plasmacytoid dendritic cell neoplasm (BPDCN) (If checked, go to 6) ☐

Myelodysplastic syndrome (MDS)/Myeloproliferative Neoplasms (MPN) Overlap Neoplasms (i.e. chronic myelomonocytic leukemia (CMML), juvenile myelomonocytic leukemia (JMML), BCR-ABL negative atypical chronic myeloid leukemia (aCML), MDS/MPN with neutrophilia, unclassifiable MDS/MPN, MDS/MPN not otherwise specified (NOS), MDS/MPN with ring sideroblasts and thrombocytosis (If checked, no further questions) ☐

MDS/MPN with SF3B1 mutation (If checked, no further questions) ☐

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 9) ☐

6. Is the requested drug being used for systemic disease with palliative intent? **Y** ☐ **N** ☐

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

Relapsed disease (If checked, go to 8) ☐

Refractory disease (If checked, go to 8) ☐

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

_____

8. Will the requested medication be used in combination with venetoclax (Venclexta)? **Y** ☐ **N** ☐

9. What is the place in therapy in which the requested drug will be used?

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

Subsequent therapy (If checked, go to 10) ☐

10. What is the clinical setting in which the requested drug 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. Will the requested drug 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.

_____

Prescriber (Or Authorized) Signature and Date