PA Request Criteria

00-000000000

207858

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:** 7/18/2024
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 patient's diagnosis?
   - Multiple myeloma (If checked, go to 2) ☐
   - B-Cell lymphomas (HIV-related diffuse large B-cell lymphoma (DLBCL), HIV-related primary effusion lymphomas, HIV-related HHV8-positive DLBCL, DLBCL, including transformed DLBCL arising from indolent lymphoma, high grade B-cell lymphoma), and monomorphic post-transplant lymphoproliferative disorder (B-Cell type) (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 disease progression or an unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐
4. What is the patient's diagnosis?
   - Multiple myeloma (If checked, go to 5) ☐
   - B-Cell lymphomas (If checked, go to 14) ☐
5. What is the prescribed regimen?
   - The requested medication with dexamethasone (If checked, go to 6) ☐
   - The requested medication with dexamethasone and bortezomib (If checked, go to 11) ☐
   - The requested medication with dexamethasone and daratumumab (If checked, go to 11) ☐
   - The requested medication with dexamethasone and carfilzomib (If checked, go to 11) ☐
   - The requested medication with dexamethasone and pomalidomide (If checked, go to 12) ☐
   - Other, please specify. (If checked, no further questions) ☐

     _____
6. How many previous treatment regimens has the patient used?
   - 4 or more (If checked, go to 7) ☐

     _____

Less than 4 (If checked, no further questions) ☐

---

7. Is the patient refractory to at least two prior proteasome inhibitors (e.g., bortezomib, carfilzomib, ixazomib)? **Y** ☐ **N** ☐

8. Is the patient refractory to at least two prior immunomodulatory agents (e.g., thalidomide, lenalidomide, pomalidomide)? **Y** ☐ **N** ☐

9. Is the patient refractory to an anti-CD38 monoclonal antibody (e.g., daratumumab, isatuximab-irfc)? **Y** ☐ **N** ☐

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

    ---

11. What is the clinical setting in which the requested medication will be used?
    - Relapsed disease (If checked, no further questions) ☐
    - Progressive disease (If checked, no further questions) ☐
    - Other, please specify. (If checked, no further questions) ☐

    ---

12. Has the patient received at least two prior regimens, including a proteasome inhibitor (e.g., bortezomib, carfilzomib, ixazomib) and an immunomodulatory agent (e.g., lenalidomide, pomalidomide, thalidomide)? **Y** ☐ **N** ☐

13. What is the clinical setting in which the requested medication will be used?
    - Relapsed disease (If checked, no further questions) ☐
    - Progressive disease (If checked, no further questions) ☐
    - Other, please specify. (If checked, no further questions) ☐

    ---

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

15. What is the clinical setting in which the requested medication will be used?
    - Partially responsive disease (If checked, go to 16) ☐
    - Progressive disease (If checked, go to 16) ☐
    - Non-responsive disease (If checked, go to 16) ☐
    - Relapsed disease (If checked, go to 16) ☐
    - Refractory disease (If checked, go to 16) ☐
    - Other, please specify. (If checked, no further questions) ☐

    ---

16. Has the patient received at least two prior lines of systemic therapy (includes transplant or CAR T-cell therapy [e.g., Yescarta, Kymriah])? **Y** ☐ **N** ☐

17. Which of the following B-Cell lymphoma subtypes does the patient have?
    - HIV-related diffuse large B-cell lymphoma (DLBCL) (If checked, no further questions) ☐
    - HIV-related primary effusion lymphoma (If checked, no further questions) ☐
    - HIV-related HHV8-positive DLBCL (If checked, no further questions) ☐
    - DLBCL, including transformed DLBCL arising from indolent lymphomas (If checked, no further questions) ☐
    - High-grade B-cell lymphoma (If checked, no further questions) ☐

Monomorphic post-transplant lymphoproliferative disorder (B-Cell type) (If checked, no further questions) ☐

Other, please specify. (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

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.