Blincyto

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Criteria Questions:

1. What is the patient's diagnosis?
   ❑ B-cell precursor acute lymphoblastic leukemia (ALL)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #5*
4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions*
5. Are the B-cells positive for CD19? ***ACTION REQUIRED: If Yes, attach testing or analysis confirming CD19 protein on the surface of the B cell supporting chart note(s).***
   ❑ Yes ❑ No ❑ Unknown

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

6. How will the requested drug be used?
   - ❑ For treatment of Philadelphia chromosome positive (Ph+) disease
   - ❑ For treatment of Philadelphia chromosome negative (Ph-) disease
   - ❑ For treatment of Philadelphia chromosome like (Ph-like) disease
   - ❑ As a component of inotuzumab ozogamicin + mini-hyperCVD, *skip to #15*
   - ❑ Other

7. Is the patient's disease relapsed or refractory? ❑ Yes ❑ No

8. Will the requested drug be used as ANY of the following? *Select all that apply*
   - ❑ A single agent
   - ❑ With a TKI (e.g., imatinib, dasatinib)
   - ❑ Other _____

Complete the following section based on the patient's Philadelphia chromosome, if applicable

Section A: Philadelphia Positive

9. Will the requested drug be used as consolidation therapy for persistent/rising minimal residual disease (MRD) or for MRD negative disease following a complete response to induction therapy?
   - ❑ Yes, for persistent/rising minimal residual disease (MRD), *No further questions*
   - ❑ Yes, for MRD negative disease, *skip to #11*
   - ❑ No

10. Will the requested drug be used when the patient has less than complete response or minimal residual disease positive (MRD+) disease at the end of consolidation therapy? ❑ Yes ❑ No *No further questions*

11. Is the patient a candidate for multi-agent chemotherapy? ❑ Yes ❑ No

Section B: Philadelphia Negative

12. Which of the following applies to the patient's disease)
    - ❑ Minimal residual disease positive disease (MRD+) *No further questions*
    - ❑ Negative MRD (MRD-) disease
    - ❑ MRD unavailable disease

13. How will the requested drug be used?
    - ❑ As maintenance therapy
    - ❑ Following a complete response to induction therapy
    - ❑ For a patient who is not a candidate for multi-agent chemotherapy
    - ❑ Other

Section C: Philadelphia Like

14. Will the requested drug be used for minimal residual disease positive (MRD+) disease after consolidation therapy?
    - ❑ Yes ❑ No

Section D: Component of inotuzumab ozogamicin + mini-hyperCVD

15. What is the clinical setting in which the requested drug will be used?
    - ❑ Relapsed disease
    - ❑ Refractory disease
    - ❑ Other

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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