



## Breyanzi

### 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.

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**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

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Breyanzi SGM 4513-A - 09/2022.

**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062**

**Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com**

**Criteria Questions:**

1. What is the diagnosis?

- Adult Large B-cell lymphoma, *Continue to #10*
- Other, *Continue to #10*

10. Is the patient 18 years of age or older?

- Yes, *Continue to #11*
- No, *Continue to #11*

11. Does the patient have any of the following B-cell lymphoma subtypes?

- Diffuse large B-cell lymphoma (DLBCL) [including DLBCL NOS, follicular lymphoma grade 3, DLBCL arising from indolent lymphomas], *Continue to #12*
- High grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified), *Continue to #12*
- Primary mediastinal large B-cell lymphoma, *Continue to #12*
- Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphomas (including AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specified), *Continue to #13*
- Monomorphic post-transplant lymphoproliferative disorder (B-cell type), *Continue to #13*
- Other, *No Further Questions*

12. Has the patient received prior treatment with first-line chemoimmunotherapy (e.g., RCHOP [rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone])? **Action Required: If 'Yes', please attach chart notes, medical records or claims history supporting previous lines of therapy.**

- Yes, *Continue to #14*
- No, *Continue to #13*

13. Has the patient received prior treatment with two or more lines of systemic therapy? **Action Required: If 'Yes', please attach chart notes, medical records or claims history supporting previous lines of therapy.**

- Yes, *Continue to #14*
- No, *Continue to #14*

14. Does the patient have primary central nervous system lymphoma?

- Yes, *Continue to #15*
- No, *Continue to #15*

15. Does the patient have adequate and stable kidney, liver, pulmonary and cardiac function?

- Yes, *Continue to #16*
- No, *Continue to #16*

16. Does the patient have active hepatitis B, active hepatitis C, or any active uncontrolled infection?

- Yes, *Continue to #17*
- No, *Continue to #17*

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17. Does the patient have active graft versus host disease?

Yes, *Continue to #18*

No, *Continue to #18*

18. Does the patient have an active inflammatory disorder?

Yes, *Continue to #19*

No, *Continue to #19*

19. Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2 (the patient is ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours)?

Yes, *Continue to #20*

No, *Continue to #20*

20. Has the patient received a previous treatment course of the requested medication or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy (e.g., Yescarta, Kymriah)? (Internal note: Operations should check the patient's PA history to ensure the patient has not had one previous course of Breyanzi or another CD19-directed CAR T-cell therapy.)

Yes, *No Further Questions*

No, *No Further Questions*

*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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