

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



>{{PANUMCODE}}

Brukinsa

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 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at 1-866-814-5506. 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: {{MEMFIRST}} {{MEMLAST}} **Date:** {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

- What is the diagnosis?
 Mantle cell lymphoma (MCL)
 Waldenstrom Macroglobulinemia (WM)/Lymphoplasmacytic lymphoma (LL)
 Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)
 Gastric mucosa-associated lymphoid tissue (MALT) Lymphoma
 Non-Gastric MALT Lymphoma
 Nodal Marginal Zone Lymphoma
 Splenic Marginal Zone Lymphoma
 Other _____
- What is the ICD-10 code? _____
- Is the patient currently receiving treatment with the requested medication? Yes No *If No, skip to #5*
- Is there evidence of unacceptable toxicity or disease progression on the current regimen?
 Yes No *No further questions*
- If the diagnosis is mantle cell lymphoma (MCL), Waldenstrom Macroglobulinemia (WM)/lymphoplasmacytic lymphoma (LL), or chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), is the requested drug being used as a single agent?* Yes No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Mantle Cell Lymphoma (MCL)

6. Has the patient received at least one prior therapy? Yes No

Section B: Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)

7. Does the patient have an intolerance or contraindication to other bruton tyrosine kinase inhibitors (e.g., ibrutinib and acalabrutinib)? Yes No

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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Section C: Gastric MALT Lymphoma, Non-Gastric MALT Lymphoma, Nodal Marginal Zone Lymphoma, Splenic Marginal Zone Lymphoma

8. Does the patient have an intolerance to or contraindication to ibrutinib? *If Yes, skip to #12* Yes No
9. Has the patient received an anti-CD20 based-regimen (e.g., rituximab or obinutuzumab)? Yes No
10. Will the requested drug be used as subsequent therapy? Yes No

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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