

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



[[PANUMCODE]]

## Copiktra

### 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.

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](mailto: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:** {{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?  
 Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)  
 Nodal marginal zone lymphoma  Splenic marginal zone lymphoma  
 Gastric MALT lymphoma  Non-gastric MALT lymphoma  
 Follicular lymphoma  Other \_\_\_\_\_
- What is the ICD-10 code? \_\_\_\_\_
- Is this a request for continuation of therapy with the requested drug?  
 Yes  No *If No, skip to diagnosis section, if applicable*
- Is there evidence of unacceptable toxicity or disease progression while on the current regimen?  
 Yes  No *No further questions*

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

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

- Is the patient's disease relapsed or refractory?  Yes  No
- Will the requested medication be used as a single agent?  Yes  No

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

- Will the requested medication be used as subsequent therapy after at least two prior therapies?  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)**

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

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CVS Caremark Prior Authorization • 1300 E. Campbell Road • Richardson, TX 75081  
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