



2211 Sanders Road, Northbrook, IL 60062 Phone (866) 814-5506



Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}

To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (855) 330-1720

Re: Prior Authorization for {Auth.Member.MemberNameFirst}
{Auth.Member.MemberNameLast}

Electronically (4-5 minutes process time)	Phone (10-15 minutes process time)	Fax (24-72 hours process time)
<p>CVS/Caremark now accepts PA requests on-line 24/7. No fax machines, no phone hold times, faster approval.</p> <p>Most requests will not require a fax or phone call.</p> <p>To request a Prior Authorization online, navigate to https://provider.carefirst.com/providers/home.page and click on the orange tab in the upper right hand corner; or for more details about how to submit and review your prior authorization requests online, view the training video available at www.carefirst.com/learninglibrary > Pharmacy.</p>	<p>Calling us with your PA request during our business hours is another option</p> <p>The process over the phone can take between 10 and 15 minutes.</p> <p>OR online</p>	<p>You may also continue to fax us your PA request</p> <p>Faxes received are processed within 24 to 72 hours.</p> <p>OR online</p>

The information contained in this message may be privileged and confidential and protected from disclosure. If the reader of this message is not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by replying to the message and deleting it from your computer. Thank you, CVS/Caremark.

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:**
{Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}



Dacogen [decitabine]

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 Name: {Auth.Member.MemberNameFirst}
{Auth.Member.MemberNameLast}

Date: {System.DateTime.Today}

Patient's ID: {Auth.Member.MemberID}

Patient's Date of Birth:
{Auth.Member.MemberBirthDate}

Physician's Name: {Auth.ProviderBilling.Name.Legal}

Specialty: _____

NPI#: {Auth.ProviderBilling.NPI}

Physician Office Telephone: {Auth.OfficeContactPhoneNumber}

Physician Office Fax:
{Auth.OfficeContactFaxNumber}

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. Dacogen (decitabine) SGM 2288-A – 07/2023.

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

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:**
{Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Criteria Questions:

- A. What drug is being prescribed?
- Dacogen
 - decitabine HCPCS code J0894 (manufacturer not otherwise specified below)
 - decitabine HCPCS code J0893 (Sun Pharma)
 - Other _____
- B. What is the ICD-10 code? _____
1. What is the patient's diagnosis?
 - Myelodysplastic syndrome (MDS) *(If checked, go to 2)*
 - Acute myeloid leukemia (AML) *(If checked, go to 2)*
 - Accelerated phase or blast phase myelofibrosis *(If checked, go to 2)*
 - Blastic plasmacytoid dendritic cell neoplasm (BPDCN) *(If checked, go to 4)*
 - Myelodysplastic syndrome/myeloproliferative neoplasm (MDS/MPN) overlap neoplasms (i.e. chronic myelomonocytic leukemia [CMML], BCR-ABL negative atypical chronic myeloid leukemia [aCML], MDS/MPN with neutrophilia, unclassifiable MDS/MPN, MDS/MPN with ring sideroblasts and thrombocytosis) *(If checked, go to 9)*
 - Other, please specify. _____ *(If checked, no further questions)*
 2. Is the patient currently receiving treatment with the requested medication?
 - Yes, *Continue to 3*
 - No, *No Further Questions*
 3. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
 - Yes, *No Further Questions*
 - No, *No Further Questions*
 4. Is the patient currently receiving treatment with the requested medication?
 - Yes, *Continue to 5*
 - No, *Continue to 6*
 5. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
 - Yes, *No Further Questions*
 - No, *No Further Questions*
 6. Does the patient have relapsed or refractory disease?
 - Yes, *Continue to 8*
 - No, *Continue to 7*
 7. Is the requested drug being used for systemic disease with palliative intent?
 - Yes, *Continue to 8*
 - No, *Continue to 8*
 8. Will the requested medication be used in combination with venetoclax (Venclexta)?
 - Yes, *No Further Questions*
 - No, *No Further Questions*
 9. Is the patient currently receiving treatment with the requested medication?
 - Yes, *Continue to 10*
 - No, *No Further Questions*
 10. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
 - Yes, *No Further Questions*
 - No, *No Further Questions*

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{Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

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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