Darzalex

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*

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

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Multiple myeloma
   - ❑ Systemic light chain amyloidosis
   - ❑ 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 diagnosis section*
4. Has the patient experienced 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: Multiple Myeloma

5. Is the prescribed regimen the requested medication in combination with bortezomib, thalidomide, and dexamethasone?
   ❑ Yes ❑ No *If Yes, skip to #10*
6. What is the prescribed regimen?
   - ❑ The requested medication in combination with lenalidomide and dexamethasone, *skip to #13*
   - ❑ The requested medication in combination with bortezomib, melphalan, and prednisone, *skip to #16*
   - ❑ The requested medication in combination with bortezomib and dexamethasone, *skip to #18*
   - ❑ The requested medication in combination with carfilzomib and dexamethasone, *skip to #19*
   - ❑ The requested medication in combination with pomalidomide and dexamethasone
   - ❑ The requested medication as a single agent, *skip to #8*
   - ❑ Other _____
7. Has the patient received at least two prior therapies, including a proteasome inhibitor (PI) and an immunomodulatory agent? ❑ Yes ❑ No *No further questions*
8. Has the patient received at least three prior therapies, including a proteasome inhibitor (PI) and an immunomodulatory agent? *If yes, no further questions* ❑ Yes ❑ No
9. Is the patient double refractory to a PI and an immunomodulatory agent? ❑ Yes ❑ No *No further quesitons*
10. Is the patient eligible for autologous stem cell transplant? ❑ Yes ❑ No
11. Will the requested medication be used as primary therapy? ❑ Yes ❑ No
12. Will the requested medication be used for a maximum of 16 doses? ❑ Yes ❑ No *No further questions*
13. Is the patient eligible for autologous stem cell transplant? *If Yes, skip to #15* ❑ Yes ❑ No
14. Will the requested medication be used as primary therapy? *If Yes, no further questions* ❑ Yes ❑ No
15. Has the patient received one or more prior therapies? ❑ Yes ❑ No *No further questions*
16. Is the patient eligible for autologous stem cell transplant? ❑ Yes ❑ No
17. Will the requested medication be used as primary therapy? ❑ Yes ❑ No *No further questions*
18. Has the patient received at least one prior therapy? ❑ Yes ❑ No *No further questions*
19. Is the patient's disease relapsed or progressive? ❑ Yes ❑ No

Section B: Systemic Light Chain Amyloidosis

20. Is the patient's disease relapsed or refractory? ❑ 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 Specialty Programs Fax: 1-855-330-1720

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