



Elzonris

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

Clinical Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?

- Blastic plasmacytoid dendritic cell neoplasm (BPDCN) (If checked, go to 2)
 Other, please specify. _____ (If checked, go to 2)

2. Is this a request for continuation of therapy with the requested medication?

- Yes, *Continue to 3*
 No, *Continue to 4*

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. CareFirst Elzonris SGM 2831-A – 07/2023.

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3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

Yes,, *No Further Questions*

No, *No Further Questions*

4. Is the patient's disease positive for CD123 expression? ***ACTION REQUIRED:*** If Yes, attach chart note(s) or test results confirming CD123 expression.

Yes ***ACTION REQUIRED:*** Submit supporting documentation *Continue to 5*

No, *Continue to 5*

Not tested or unknown, *Continue to 5*

5. Will the requested medication be used as a single agent?

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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