Folotyn

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*

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

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Peripheral T-cell lymphoma (PTCL) (including the following subtypes: anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with T-follicular helper (TFH) phenotype, or follicular T-cell lymphoma)
   - ❑ Adult T-cell leukemia/lymphoma (ATLL)
   - ❑ Mycosis fungoides (MF)
   - ❑ Sezary syndrome (SS)
   - ❑ Cutaneous anaplastic large cell lymphoma (ALCL)
   - ❑ Extranodal NK/T-cell lymphoma, nasal type
   - ❑ Hepatosplenic T-cell lymphoma
   - ❑ Breast implant-associated anaplastic large cell lymphoma (ALCL)
   - ❑ 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 #5*
4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions*
5. How will the requested drug be used? ***Indicate ALL that apply.***
   ❑ As a single agent ❑ As second-line or subsequent therapy ❑ None of the above

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

Section A: Peripheral T-Cell Lymphoma (PTCL)

6. Which of the following conditions does the patient meet?
   - ❑ The disease is relapsed or refractory
   - ❑ The requested medication will be used for initial palliative intent
   - ❑ None of the above

Section B: Extranodal NK/T-Cell Lymphoma (Nasal Type)

7. Is the disease relapsed or refractory? ❑ Yes ❑ No
8. Has the patient had an inadequate response to asparaginase-based therapy (e.g., pegaspargase)?
   If Yes, no further questions. ❑ Yes ❑ No
9. Does the patient have a contraindication to asparaginase-based therapy (e.g., pegaspargase)? ❑ Yes ❑ No

Section C: Hepatosplenic T-Cell Lymphoma

10. How many previous lines of chemotherapy has the patient received? _____ lines

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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