Imbruvica (for Maryland only)

Prior Authorization Request

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

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

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the patient's diagnosis?
   - ❑ Mantle cell lymphoma (MCL)
   - ❑ Waldenstrom's Macroglobulinemia/lymphoplasmacytic lymphoma
   - ❑ Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL)
   - ❑ Marginal zone lymphoma
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement?
   ❑ Yes ❑ No *If No, skip to diagnosis section*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ACTION REQUIRED: ***Attach documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)*** ❑ Yes ❑ No
5. Is the medication effective in treating the member's condition?
   ❑ Yes ❑ No *Continue to diagnosis section and complete this form in its entirety.*

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

Section A: Mantle Cell Lymphoma (MCL)

6. Has the patient received at least one prior therapy for MCL? ❑ Yes ❑ No
   **Note: Examples of therapies for MCL include, but are not limited to, chemotherapy plus Rituxan, radiation therapy, Velcade, Revlimid and stem cell transplantation.*

Section B: Marginal Zone Lymphoma

7. Does the patient require systemic therapy? ❑ Yes ❑ No
8. Has the patient previously received an anti-CD20-based therapy (e.g., Rituxan)? ❑ 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)**