CVS caremark™ {{PANUMCODE}}

# Intron A

## 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 1-866-249-6155**. 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.

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:** {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
**Patient's ID** {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
**Physician's Name:** {{PHYFIRST}} {{PHYLAST}}
**Specialty: _____, NPI#: _____**
**Physician Office Telephone:** {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
**Request Initiated For:** {{DRUGNAME}}

1. What is the diagnosis?
   - ❑ Malignant melanoma
   - ❑ Mycosis fungoides
   - ❑ Sezary syndrome
   - ❑ Adult T-cell leukemia/lymphoma (ATLL)
   - ❑ Hairy cell leukemia
   - ❑ Follicular lymphoma, clinically aggressive
   - ❑ Myelofibrosis, symptomatic low-risk
   - ❑ Essential thrombocythemia
   - ❑ Polycythemia vera
   - ❑ Renal cell carcinoma
   - ❑ Condylomata acuminata
   - ❑ AIDS-related Kaposi sarcoma
   - ❑ Chronic myeloid leukemia (CML)
   - ❑ Giant cell tumor of the bone
   - ❑ Desmoid tumors
   - ❑ Chronic hepatitis B virus (including Hepatitis D co-infection)
   - ❑ Chronic hepatitis C virus
   - ❑ Systemic mastocytosis
   - ❑ Carcinoid syndrome
   - ❑ Hypereosiniphilic syndrome
   - ❑ Ocular surface neoplasia (conjunctival and corneal neoplasm)
   - ❑ Respiratory papillomatosis
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No
   ***For Chronic Hepatitis C or Chronic Hepatitis B diagnoses:*** *If No, no further questions.*
   ***For All Other Indications:*** *If No, skip to #6.*

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

4. Is the patient receiving clinical benefit from the requested drug while on the current regimen?
   ❑ Yes ❑ No ❑ Not applicable - diagnosis is not Chronic Hepatitis C or Chronic Hepatitis B

5. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes - unacceptable toxicity ❑ Yes - disease progression ❑ No *No further questions*

6. How will the requested drug be used? *Indicate ALL that apply.*
   ❑ As a single agent
   ❑ In combination with zidovudine
   ❑ In combination with arsenic trioxide (Trisenox)
   ❑ In combination with bevacizumab
   ❑ None of the above
   ❑ As subsequent therapy
   ❑ In combination with denosumab
   ❑ In combination with prednisone
   ❑ With antiretroviral therapy

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

Section A: Hypereosinophilic Syndrome

7. Has the patient had an inadequate response to corticosteroids? *If Yes, no further questions.* ❑ Yes ❑ No

8. Does the patient have a contraindication to corticosteroids? ❑ 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 Prior Authorization Fax: 1-866-249-6155**