



Poteligeo

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

- 1. What is the diagnosis?
[] Mycosis fungoides (MF)
[] Sézary syndrome (SS)
[] Adult T-cell leukemia/lymphoma
[] 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 next section (if applicable)
4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
[] Yes [] No No further questions

Complete the following questions if the patient's diagnosis is adult T-cell leukemia/lymphoma

- 5. Will Poteligeo be used as a single-agent second line or subsequent therapy? [] Yes [] No
6. What is the patient's adult T-cell leukemia/lymphoma subtype?
[] Chronic/smoldering
[] Acute
[] Lymphoma
[] None of the above/unknown

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)