CareFirst Family of health care plans

CVS caremark™

Revlimid

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?
   - ❑ Multiple myeloma
   - ❑ Non-Hodgkin lymphoma
   - ❑ Myelodysplastic syndrome
   - ❑ Myelofibrosis-associated anemia
   - ❑ Systemic light chain amyloidosis
   - ❑ Classical Hodgkin lymphoma
   - ❑ Other _____

2. What is the ICD-10 code? _____

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

Section A: Non-Hodgkin Lymphoma

3. Which of the following NHL subtypes does the patient have?
   - ❑ Diffuse large B-cell lymphoma
   - ❑ Mantle cell lymphoma
   - ❑ Chronic lymphocytic leukemia (CLL) / small lymphocytic lymphoma (SLL)
   - ❑ Primary cutaneous B-cell lymphoma
   - ❑ AIDS-related diffuse large B-cell lymphoma
   - ❑ Primary effusion lymphoma
   - ❑ Lymphoma associated with Castleman's disease
   - ❑ Follicular lymphoma
   - ❑ Peripheral T-cell lymphoma not otherwise specified (PTCL NOS)
   - ❑ Other _____
   - ❑ Nongastric/gastric MALT lymphoma
   - ❑ Splenic marginal zone lymphoma
   - ❑ Castleman's disease
   - ❑ Primary cutaneous anaplastic large cell lymphoma (ALCL)
   - ❑ Adult T-cell leukemia/lymphoma
   - ❑ Mycosis fungoides (MF)/Sezary syndrome (SS)
   - ❑ Angioimmunoblastic T-cell lymphoma (AITL)
   - ❑ Enteropathy-associated T-cell lymphoma

4. *If Castleman's disease*, what is the form of the disease? ❑ Unicentric ❑ Multicentric

Section B: Myelodysplastic Syndrome

5. What is the International Prognostic Scoring System (IPSS) risk category of the disease?
   ❑ Low ❑ Intermediate-1 ❑ Intermediate-2 ❑ High

6. Does the patient have symptomatic anemia? ❑ 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)**