Treanda, Bendeka (for Maryland only)

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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 **1-866-814-5506.** 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:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Criteria Questions:

1. What drug is being prescribed?
   ❑ Treanda ❑ Bendeka ❑ Other _____
2. What is the diagnosis?
   ❑ Adult T-cell leukemia/lymphoma (ATLL) (Non-Hodgkin's lymphoma)
   ❑ Primary cutaneous CD30+ T-cell lymphoproliferative disorders
   ❑ Classical Hodgkin lymphoma
   ❑ Peripheral T-cell Lymphoma (PTCL)
   ❑ Mycosis Fungoides (MF)/Sezary syndrome (SS)
   ❑ Diffuse large B-cell lymphoma (Non-Hodgkin's lymphoma)
   ❑ AIDS-related B-cell lymphoma (Non-Hodgkin's lymphoma)
   ❑ Chronic lymphocytic leukemia (CLL) (Non-Hodgkin's lymphoma)
   ❑ Small lymphocytic lymphoma (SLL) (Non-Hodgkin's lymphoma)
   ❑ Follicular lymphoma (Non-Hodgkin's lymphoma)
   ❑ Marginal zone lymphoma (eg, gastric MALT, non-gastric MALT, splenic marginal zone) (Non-Hodgkin's lymphoma)
   ❑ Primary cutaneous B-cell lymphoma (Non-Hodgkin's lymphoma)
   ❑ Mantle cell lymphoma (Non-Hodgkin's lymphoma)
   ❑ Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma (Non-Hodgkin's lymphoma)
   ❑ Multiple myeloma
   ❑ Other
3. What is the ICD-10 code? _____
4. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #7*

5. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
❑ Yes ❑ No ACTION REQUIRED: ***Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***

6. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #7 and complete this form in its entirety.*

7. Which type of disease does the patient have?
❑ Progressive
❑ Relapsed
❑ Refractory
❑ Other _____

8. What is the prescribed regimen?
❑ Bendamustine monotherapy
❑ Bendamustine + rituximab (Rituxan)
❑ Bendamustine + obinutuzumab (Gazyva)
❑ Bendamustine + lenalidomide (Revlimid) + dexamethasone
❑ Other _____

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

Section A: Adult T-cell Leukemia/Lymphoma (ATLL) (Non-Hodgkin's lymphoma)
9. Is the patient a non-responder to first-line therapy? ❑ Yes ❑ No

10. Will bendamustine be used for acute disease or lymphoma? ❑ Yes ❑ No

Section B: Primary Cutaneous CD30+ T-cell Lymphoproliferative Disorders
11. Does the patient have cutaneous anaplastic large cell lymphoma? ❑ Yes ❑ No

Section C: Diffuse Large B-cell Lymphoma and AIDS-Related B-cell Lymphoma
9. Is the patient a candidate for high-dose therapy? ❑ Yes ❑ No

Section D: Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)
12. Does the patient have chromosome 17p deletion? ❑ Yes ❑ No
ACTION REQUIRED: Attach chromosome 17q deletion test result.

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)**