CVS caremark™ {{PANUMCODE}}

Turalio

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 patient's diagnosis?
   ❑ Tenosynovial giant cell tumor (TGCT) ❑ Pigmented villonodular synovitis (PVNS)
   ❑ Histiocytic neoplasms ❑ Other _____
2. What is the ICD-10 code? _____
3. Will the requested drug be used as a single agent? ❑ Yes ❑ No
4. Is the patient currently receiving treatment with the requested medication?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*
5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions.*

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

Section A: Histiocytic Neoplasms

6. Does the patient have any of the following subtypes?
   ❑ Erdheim-Chester disease (ECD) ❑ Rosai-Dorfman disease (RDD)
   ❑ Langerhans cell histiocytosis (LCH), *skip to #8* ❑ Other _____
7. Is the disease symptomatic or relapased/refractory?
   ❑ Symptomatic disease ❑ Relapsed/ refractory disease ❑ Other _____
8. Does the patient have a colony stimulating factor 1 receptor (CSF1R) mutation? ***ACTION REQUIRED: Attach supporting chart notes or lab results.*** ❑ Yes ❑ No ❑ 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)**

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