Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

CVS caremark™ {{PANUMCODE}}

Vanflyta

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?
   ❑ Acute myeloid leukemia (AML)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #6*
4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? ❑ Yes ❑ No
5. How many months of maintenance therapy with the requested drug has the patient received?
   Indicate below and no further questions.
   ❑ Greater than or equal to 36 months ❑ 35 months ❑ 34 months
   ❑ 33 months ❑ 32 months ❑ 31 months ❑ 24 months or less
   ❑ 30 months ❑ 29 months ❑ 28 months
   ❑ 27 months ❑ 26 months ❑ 25 months
6. Has the patient been newly diagnosed with acute myeloid leukemia (AML)?
   ❑ Yes ❑ No
7. Does the patient have a positive FLT3 internal tandem duplication (ITD) mutation? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of FLT3 internal tandem duplication (ITD) mutation status***.
   ❑ Yes ❑ No ❑ Unknown
8. Will the requested medication be used as single-agent maintenance therapy following hematopoietic stem cell transplantation (HSCT)? ❑ 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