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

CVS caremark™ {{PANUMCODE}}

Venclexta

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 diagnosis?
   - ❑ Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)
   - ❑ Acute myeloid leukemia (AML), newly-diagnosed
   - ❑ Acute myeloid leukemia (AML), relapsed or refractory
   - ❑ Mantle cell lymphoma
   - ❑ Blastic plasmacytoid dendritic cell neoplasm (BPDCN)
   - ❑ Multiple myeloma
   - ❑ 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 diagnosis section*
4. Does the member have the diagnosis of chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)?
   ❑ Yes ❑ No *If No, skip to #8*
5. What is the prescribed regimen?
   - ❑ The requested medication as monotherapy, *skip to #8*
   - ❑ The requested medication with rituximab (Rituxan)
   - ❑ The requested medication with obinutuzumab (Gazyva), *skip to #7*
   - ❑ Other _____
6. Will the patient receive more than 24 months of the requested medication and rituximab (Rituxan) therapy (starting with cycle 1, day 1 of rituximab initiation)? ❑ Yes ❑ No *If No, skip to #8*
7. Will the patient receive more than 12 cycles of the requested medication and obinutuzumab (Gazyva) therapy?
   ❑ Yes ❑ No
8. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions*

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

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

Section A: Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL)

9. What is the prescribed regimen?
   - ❑ The requested medication as monotherapy
   - ❑ The requested medication with rituximab (Rituxan)
   - ❑ The requested medication with obinutuzumab (Gazyva)
   - ❑ Other _____

Section B: Acute Myeloid Leukemia (AML), Newly-Diagnosed

10. What is the prescribed regimen? *If patient is greater than or equal to 75 years old, no further questions.*
    - ❑ The requested medication with decitabine
    - ❑ The requested medication with azacitidine
    - ❑ The requested medication with low-dose cytarabine
    - ❑ Other _____

11. Does the patient have comorbidities that preclude the use of intensive induction chemotherapy?
    ❑ Yes ❑ No *If patient is less than 60 years old (physiologic age), no further questions.*

12. Is the patient a candidate for intensive remission induction therapy with unfavorable-risk cytogenetics?
    If Yes, no further questions ❑ Yes ❑ No

13. Is the patient not a candidate for intensive remission induction therapy or declines intensive therapy?
    If Yes, no further questions ❑ Yes ❑ No

14. Will the requested medication be used as post-induction therapy following response to a Venclexta-based regimen? ❑ Yes ❑ No

Section C: Acute Myeloid Leukemia (AML), Relapsed or Refractory

15. Will the requested medication be used in combination with any of the following?
    ❑ Azacitidine ❑ Decitabine ❑ Low-dose cytarabin ❑ None of the these

Section D: Mantle Cell Lymphoma

16. Will the requested medication be used as subsequent therapy? ❑ Yes ❑ No

17. What is the prescribed regimen?
    - ❑ The requested medication used as a single agent
    - ❑ The requested medication with rituximab (Rituxan)
    - ❑ The requested medication with ibrutinib (Imbruvica)
    - ❑ Other _____

Section E: Blastic Plasmacytoid Dendritic Cell Neoplasm (BPDCN)

18. Will the requested medication be used in combination with any of the following:
    ❑ Azacitidine ❑ Decitabine ❑ Low-dose cytarabin ❑ None of the these

Section F: Multiple Myeloma

19. Will the requested medication be used for treatment of relapsed or progressive multiple myeloma?
    ❑ Yes ❑ No

20. Does the member have a documented translocation t(11,14)? ***ACTION REQUIRED: If Yes, attach supporting documentation.*** ❑ Yes ❑ No

21. Will the requested medication be used in combination with dexamethasone? ❑ 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)**

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