CareFirst Family of health care plans

CVS caremark™

Zydelig
Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs 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 prescribed daily dose? _____ mg per day

2. What is the patient's diagnosis?
   - ❑ Follicular B-cell non-Hodgkin lymphoma (FL)
   - ❑ Small lymphocytic lymphoma (SLL)
   - ❑ Chronic lymphocytic leukemia (CLL)
   - ❑ Primary cutaneous B-cell lymphoma
   - ❑ Gastric MALT lymphoma
   - ❑ Non-gastric MALT lymphoma
   - ❑ Splenic marginal zone lymphoma
   - ❑ Other _____

3. What is the ICD-10 code? _____

4. *If patient as primary cutaneous B-cell lymphoma,* what types of primary cutaneous B-cell lymphoma does the patient have? ***If applicable, indicate below and no further questions.***
   - ❑ Primary cutaneous marginal zone lymphoma
   - ❑ Follicle center lymphoma
   - ❑ Other _____
   - ❑ Not applicable (not patient's diganosis), *continue to #5*

5. Is the disease: ❑ Relapsed ❑ Refractory ❑ Progressive ❑ Recurrent ❑ Other _____

6. *If patient's diagnosis is SLL or CLL,* what is the prescribed regimen?
   - ❑ Zydelig monotherapy
   - ❑ Zydelig + rituximab (Rituxan)
   - ❑ Other _____
   - ❑ Not applicable

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)**