Zynlonta

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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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.

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Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** __________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** _____________________

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** _____________________

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

Required Demographic Information:

Patient Weight: __________________________*kg*

Patient Height: __________________________*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

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Clinical Criteria Questions:

1. What is the diagnosis?
   - ❑ AIDS-Related B-cell lymphomas (AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma)
   - ❑ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma
   - ❑ Large B-cell lymphoma (e.g., diffuse large B-cell lymphoma [DLBCL] not otherwise specified [NOS], DLBCL arising from low grade lymphoma, high-grade B-cell lymphoma)
   - ❑ 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 diagnosis section*

4. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No *No further questions*

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

Section A: Large B-cell Lymphoma and AIDs-Related B-cell lymphomas

5. What is the clinical setting in which the requested drug will be used?
   - ❑ Relapsed disease
   - ❑ Refractory disease
   - ❑ Progressive disease
   - ❑ Other________________________________

6. Has the patient received two or more prior lines of systemic therapy? ***ACTION REQUIRED: If Yes, please attach chart notes, medical records documentation or claims history supporting previous lines of therapy.***
   ❑ Yes ❑ No

7. Will the requested drug be used as a single agent? ❑ Yes ❑ No

Section B: Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma

8. Will the requested drug be used as subsequent therapy? ❑ Yes ❑ No

9. Is the patient a candidate for transplant? ❑ 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 Specialty Programs Fax: 1-855-330-1720

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