Copiktra

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: ______________________________ **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 diagnosis?
   ❑ Follicular lymphoma ❑ Gastric MALT lymphoma ❑ Non-gastric MALT lymphoma
   ❑ Nodal marginal zone lymphoma ❑ Splenic marginal zone lymphoma
   ❑ Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
   ❑ 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, if applicable*
4. Has the patient experienced unacceptable toxicity or disease progression?
   ❑ Yes ❑ No *No further questions*

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

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

5. Is the patient's disease relapsed or refractory? ❑ Yes ❑ No
6. Will the requested medication be used as a single agent? ❑ Yes ❑ No

<u>Section B: Follicular Lymphoma (FL)</u>

7. Will the requested medication be used as second-line or subsequent therapy? ❑ Yes ❑ No

<u>Section C: Gastric MALT Lymphoma, Non-Gastric MALT Lymphoma, Nodal Marginal Zone Lymphoma, Splenic Marginal Zone Lymphoma</u>

8. Will the requested medication be used as subsequent therapy after at least two prior therapies? ❑ 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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Copiktra SGM - 1/2020.