

Farydak (for Maryland only)
Prior Authorization Request

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization 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 copy 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: _____ NPI#: _____
Specialty: _____ Physician Office Telephone: _____ Physician Office Fax: _____
Request Initiated For: _____

1. What is the patient's diagnosis?
 Multiple myeloma
 Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? Yes No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.) Yes No
5. Is the medication effective in treating the member's condition? Yes No *Continue to #6 and complete this form in its entirety.*
6. How many different treatment regimens has the patient previously received (not including the requested regimen)? _____
7. Has the patient received prior therapy with Velcade (bortezomib)? Yes No *If No, no further questions*
8. Which of the following agent(s) has the patient received as part of a prior regimen?
Indicate below or mark "None of the above."
 Revlimid [lenalidomide]
 Thalomid [thalidomide]
 Pomalyst [pomalidomide]
 Other _____
 None of the above

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)

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. Farydak CF - 5/2017.

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