

**Velcade (for Maryland only)
 Prior Authorization Request**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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 **1-866-814-5506**. 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:** _____

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

Additional Demographic Information:

Patient Weight: _____ *kg*
Patient Height: _____ *ft* _____ *inches*

Criteria Questions:

1. What is the patient's diagnosis?

<input type="checkbox"/> Multiple Myeloma	<input type="checkbox"/> Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma
<input type="checkbox"/> Mantle Cell Lymphoma	<input type="checkbox"/> Systemic Light Chain Amyloidosis
<input type="checkbox"/> Castleman's Disease	<input type="checkbox"/> Other _____
2. What is the ICD-10 code? _____
If patient's diagnosis is mantle cell lymphoma, systemic light chain amyloidosis or Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma, no further questions.
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?
 Yes No **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.)**
5. Is the medication effective in treating the member's condition? Yes No *Continue to #6 and complete this form in its entirety.*
6. What is the prescribed regimen?

<input type="checkbox"/> Velcade monotherapy	<input type="checkbox"/> Velcade, melphalan and prednisone
<input type="checkbox"/> Velcade and rituximab	<input type="checkbox"/> Other _____

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

Section A: Multiple Myeloma

7. What is the intent of treatment? ***If intent is Maintenance or Salvage therapy, no further questions.***

<input type="checkbox"/> Primary therapy	<input type="checkbox"/> Maintenance therapy	<input type="checkbox"/> Salvage therapy
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8. Will the prescribed regimen include dexamethasone? *If Yes, no further questions* Yes No

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. Velcade CF - 5/2016.

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9. Is the member a candidate for stem cell transplantation? Yes No

Section B: Castleman's Disease

10. Did the disease progress following treatment of relapsed, refractory, or progressive disease? Yes No

11. What is the form of the disease? Unicentric Multicentric

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)