Treanda, Bendamustine, Bendeka, Belrapzo, Vivimusta

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

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 (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____*Route of administration* _____
Dosing frequency _____

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Criteria Questions:

1. What drug is being prescribed? ❑ Treanda ❑ Bendeka ❑ Belrapzo
   ❑ bendamustine (Treanda) HCPCS code J9033 ❑ bendamustine (Bendeka) HCPCS code J9034
   ❑ bendamustine (Belrapzo) HCPCS code J9036 ❑ Bendamustine (Apotex) HCPCS code J9058
   ❑ Bendamustine (Baxter) HCPCS code J9059 ❑ Vivimusta ❑ Other _____

2. What is the diagnosis?
   ❑ Follicular lymphoma
   ❑ Chronic lymphocytic leukemia (CLL) without chromosome 17p deletion or without TP53 mutation
   ❑ Small lymphocytic lymphoma (SLL) without chromosome 17p deletion or without TP53 mutation
   ❑ Diffuse large B-cell lymphoma (DLBCL)
   ❑ Adult T-cell leukemia/lymphoma (ATLL)
   ❑ AIDS-related B-cell lymphoma (AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma)
   ❑ Marginal zone lymphoma (nodal, gastric MALT, non-gastric MALT, splenic)
   ❑ Mantle cell lymphoma (MCL)
   ❑ Peripheral T-cell Lymphoma (PTCL) [including the following subtypes: anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with TFH phenotype, or follicular T-cell lymphoma
   ❑ Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma
   ❑ Multiple myeloma
   ❑ Classical Hodgkin lymphoma
   ❑ Post-transplant lymphoproliferative disorders
   ❑ Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma
   ❑ High grade B-cell lymphoma
   ❑ Hepatosplenic T-Cell lymphoma
   ❑ Breast implant associated anaplastic large cell lymphoma (ALCL)
   ❑ Systemic light chain amyloidosis
   ❑ Nodular lymphocyte predominant Hodgkin lymphoma (NLPHL)
   ❑ Hematopoietic cell Transplantation
   ❑ Other _____

3. What is the ICD-10 code? _____

4. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #6*

5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions*

6. What is the requested regimen? *Indicate ALL that apply.*
   ❑ The requested drug will be used as a single agent
   ❑ The requested drug will be used as subsequent therapy
   ❑ The requested drug will be used as palliative therapy
   ❑ The requested drug will be used in combination with rituximab
   ❑ The requested drug will be used in combination with obinutuzumab (Gazyva)
   ❑ The requested drug will be used in combination with lenalidomide (Revlimid) and dexamethasone
   ❑ The requested drug will be used in combination with bortezomib (Velcade) and dexamethasone
   ❑ The requested drug will be used in combination with brentuximab vedotin (Adcetris)
   ❑ The requested drug will be used in combination with gemcitabine and vinorelbine
   ❑ The requested drug will be used in combination with carboplatin and etoposide
   ❑ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy)
   ❑ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy) and rituximab

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- ❑ The requested drug will be used as a component of RBAC500 (rituximab, bendamustine, and cytarabine)
- ❑ The requested drug will be used in combination with dexamethasone
- ❑ The requested drug will be used in combination with etoposide, cytarabine and melphalan
- ❑ None of the above

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

Section A: Diffuse Large B-Cell Lymphoma (DLBCL)

7. Will the requested drug be used as a bridging option until CAR T-cell product is available? ❑ Yes ❑ No

8. Is the patient a candidate for transplant? ❑ Yes ❑ No

Section B: High-Grade B-Cell Lymphoma, AIDS-Related B-Cell Lymphoma (AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma)

9. Will the requested drug be used as a bridging option until CAR T-cell product is available?
   ❑ Yes *If Yes, no further questions* ❑ No

10. Is the patient a candidate for transplant? ❑ Yes ❑ No

Section C: Histologic Transformation of indolent Lymphomas to Diffuse Large B-Cell Lymphoma

11. Is the patient a candidate for transplant? ❑ Yes ❑ No

Section D: Cutaneous Anaplastic Large Cell Lymphoma (ALCL)

12. Is the disease relapsed or refractory? ❑ Yes ❑ No

Section E: Post Transplant Lymphoproliferative disorders

13. Will the requested drug be used as a bridging option until CAR T-cell product is available? ❑ Yes ❑ No

14. Is the patient a candidate for transplant? ❑ Yes ❑ No

Hepatosplenic T-Cell lymphoma

15. Is the disease refractory? ❑ Yes ❑ No

16. Has the patient received TWO first-line therapy regiments? ❑ Yes ❑ No

Section F: Multiple Myeloma

17. Is the disease relapsed or progressive? ❑ Yes ❑ No

Section G: Systemic Light Chain Amyloidosis

18. What is the clinical setting in which the requested drug will be used?
   - ❑ Relapsed disease
   - ❑ Refractory disease
   - ❑ Other

Section H: Hematopoietic Cell Transplantation

19. Will the requested drug be used as conditioning for autologous 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)**

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