



Velcade (Bortezomib)

HMSA - 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 1-866-237-5512.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414**. 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:** _____
Patient's Phone Number: _____
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. Indicate where the drug is being administered:
 Ambulatory surgical Home Inpatient hospital Office Outpatient treatment center Pharmacy
2. Which drug is being prescribed? Velcade Bortezomib
3. What is the ICD-10 code? _____
4. What is the patient's diagnosis? ***Action Required: Please attach current oncology notes, clinical notes that include the history of previous treatments, and any pertinent pathology reports and/or imaging studies.***
 Systemic light chain amyloidosis
 Waldenström's Macroglobulinemia/Lymphoplasmacytic lymphoma
 Active (symptomatic) multiple myeloma
 Mantle Cell Lymphoma
 Castleman's disease
 Other _____
5. What is the specialty of the practitioner who recommended Velcade (Bortezomib)?
 Hematologist Oncologist Other _____
6. Is this request for a new start or a continuation of Velcade (Bortezomib) therapy?
If New start, skip to #9 New start Continuation
7. Was Velcade (Bortezomib) previously authorized by HMSA/CVS for this member?
 Yes No *If No, skip to #9* Unknown *If Unknown, skip to #9*

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

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8. Is there any evidence of disease progression? **Action Required:** *Please attach documentation including clinical notes and objective findings (imaging studies, beta-2 microglobulin, serum free light chain assay, or serum immunoglobulin) that demonstrate lack of disease progression on therapy.* Yes No *No further questions*
9. Indicate which therapy Velcade (Bortezomib) will be used in combination with:
- | | |
|---|--|
| <input type="checkbox"/> Nothing/Used as monotherapy | <input type="checkbox"/> Dexamethasone and doxorubicin |
| <input type="checkbox"/> Dexamethasone | <input type="checkbox"/> Dexamethasone and Doxil (liposomal doxorubicin) |
| <input type="checkbox"/> Dexamethasone and cyclophosphamide | <input type="checkbox"/> Dexamethasone and Revlimid (lenalidomide) |
| <input type="checkbox"/> Dexamethasone and melphalan | <input type="checkbox"/> Dexamethasone and Treanda (bendamustine) |
| <input type="checkbox"/> Dexamethasone and Rituxan (rituximab) | <input type="checkbox"/> Dexamethasone and Darzalex (daratumumab) |
| <input type="checkbox"/> Rituxan (rituximab) | <input type="checkbox"/> Dexamethasone and pomalidomide |
| <input type="checkbox"/> Dexamethasone and Empliciti (elotuzumab) | <input type="checkbox"/> Dexamethasone and Thalomid (thalidomide) |
| <input type="checkbox"/> Dexamethasone and Farydak (panobinostat) | |
| <input type="checkbox"/> VTD-PACE (dexamethasone, thalidomide, cisplatin, doxorubicin, cyclophosphamide, and etoposide) | |
| <input type="checkbox"/> VR-CAP (bortezomib, rituximab, cyclophosphamide, doxorubicin, and prednisone) | |
| <input type="checkbox"/> Other _____ | |

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

Section A: Systemic Light Chain Amyloidosis

- 10 Will Velcade (Bortezomib) be used as primary therapy? Yes No

Section B: Multiple Myeloma

11. Was the patient diagnosed with active myeloma, defined as clonal bone marrow plasma cells $\geq 10\%$ or biopsy-proven bony or extramedullary plasmacytoma AND one or more of the following myeloma-defining events?

Indicate any/all that apply.

- Serum calcium elevation greater than 11mg/dL or more than 1mg/dl higher than the upper limit of normal
- Renal insufficiency (serum creatinine greater than 2mg/dL or creatinine clearance $< 40\text{ml/min}$)
- Anemia (hemoglobin level less than 10g/dL OR at least 2 g/dL below lower limit of normal)
- Osteolytic bone lesions on X-ray, CT or PET-CT
- Clonal bone marrow plasma cells $\geq 60\%$
- Abnormal serum free light chain (FLC) ratio ≥ 100 (involved kappa) or < 0.01 (involved lambda)
- More than 1 focal lesions on MRI studies $> 5\text{mm}$
- None of the above
12. Indicate how Velcade (Bortezomib) will be used:
- Primary therapy
- Maintenance therapy, *no further questions*
- Therapy for previously treated or relapsed disease, *skip to #14*
13. Is the member eligible for stem cell transplant? Yes No *No further questions*
14. Will Velcade (Bortezomib) be used as part of the same chemotherapy regimen as the member's primary therapy regimen? Yes No *If No, skip to #17*
15. Was the patient off of their primary chemotherapy for at least 6 months before relapse? Yes No
16. Was the patient a transplant candidate at the time of their primary chemotherapy regimen?
 Yes No *No further questions*
17. *If Velcade (Bortezomib) is to be used in combination with Dexamethasone and pomalidomide*, Did the patient receive at least 2 prior regimens including proteasome inhibitor and an immunomodulatory agent and have demonstrated disease progression on or within 60 days of completion of the last therapy?
 Yes No *No further questions*
18. *If Velcade (Bortezomib) is to be used in combination with Dexamethasone and Farydak*, Did the patient receive at least 2 prior regimens including Velcade (bortezomib) and an immunomodulatory agent? Yes No *No further questions*

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19. *If Velcade (Bortezomib) is to be used in combination with Dexamethasone and Emlipiti, Did the patient receive 1-3 prior therapies?* Yes No *No further questions*

Section C: Mantle Cell Lymphoma

20. In what setting will Velcade (Bortezomib) be used?
- Induction
 - Second-line therapy for relapsed, refractory, or progressive disease
 - Other _____

Section D: Castleman's Disease

21. Will Velcade (Bortezomib) be used to treat multicentric Castleman's disease? Yes No
22. Will Velcade (Bortezomib) be used as subsequent therapy for disease that has progressed following treatment of relapsed/refractory or progressive disease? 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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