Prescriber Criteria Form
Copiktra 2025 PA Fax 2755-A v1 010125.docx
Copiktra (duvelisib)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Copiktra (duvelisib).

Drug Name:
Copiktra (duvelisib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of any of the following: A) chronic lymphocytic leukemia (CLL), B) small lymphocytic lymphoma (SLL), C) breast implant-associated anaplastic large cell lymphoma (ALCL), D) peripheral T-Cell lymphoma? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Is the disease relapsed or refractory? [No further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of hepatosplenic T-Cell lymphoma? [If no, then no further questions.]	Yes ◯	No ◯
4	Is the disease refractory?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____