Prescriber Criteria Form

Valchlor 2025 PA Fax 1044-A v1 010125.docx
Valchlor (mechlorethamine gel)
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 Valchlor (mechlorethamine gel).

Drug Name:
Valchlor (mechlorethamine gel)

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 stage IA or IB mycosis fungoides-type cutaneous T-cell lymphoma? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of chronic or smoldering adult T-cell leukemia or lymphoma (ATLL)? [If yes, then no further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of stage 2 or higher mycosis fungoides (MF) or Sezary syndrome (SS)? [If yes, then no further questions.]	Yes ◯	No ◯
4	Does the patient have a diagnosis of primary cutaneous marginal zone lymphoma? [If yes, then no further questions.]	Yes ◯	No ◯
5	Does the patient have a diagnosis of primary cutaneous follicle center lymphoma? [If yes, then no further questions.]	Yes ◯	No ◯
6	Does the patient have a diagnosis of CD30-positive lymphomatoid papulosis (LyP)? [If yes, then no further questions.]	Yes ◯	No ◯
7	Is the requested drug being used for the treatment of unifocal Langerhans cell histiocytosis (LCH) with isolated skin disease?	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:_____