Prescriber Criteria Form

Velcade BDC 2025 PA Fax 763-A v1 010125.docx
Velcade (bortezomib)
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 Velcade (bortezomib).

Drug Name:
Velcade (bortezomib)

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.

B vs D CRITERIA FOR DETERMINATION

1	Is the requested drug being supplied from the physician and/or office stock and billed as part of a physician service (i.e., the drug is being furnished “incident to a physician’s service”)? [If yes, then no further questions.]	Yes ◯	No ◯

CRITERIA FOR APPROVAL

2	Does the patient have ANY of the following diagnoses: A) multiple myeloma, B) mantle cell lymphoma, C) multicentric Castleman’s disease, D) systemic light chain amyloidosis, E) Waldenstrom’s macroglobulinemia/lymphoplasmacytic lymphoma, F) adult T-cell leukemia/lymphoma, G) acute lymphoblastic leukemia, H) Kaposi’s sarcoma, I) pediatric Classic Hodgkin lymphoma, J) POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome?	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:_____