

Prescriber Criteria Form

Monjuvi 2024 PA Fax 4057-A v2 010124.docx  
Monjuvi (tafasitamab-cxix)  
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 Monjuvi (tafasitamab-cxix).

Drug Name:  
Monjuvi (tafasitamab-cxix)

**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) diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including DLBCL arising from low grade lymphoma, B) HIV-related B-cell lymphoma, C) monomorphic post-transplant lymphoproliferative disorder (B-cell type), D) high-grade B-cell lymphoma? [If no, then skip to question 4.]	Yes	No
2	Is the disease relapsed or refractory? [If no, then no further questions.]	Yes	No
3	Is the patient eligible for autologous stem cell transplant (ASCT)? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of follicular lymphoma? [If no, then no further questions.]	Yes	No
5	Is the disease refractory, relapsed, or progressive?	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:** \_\_\_\_\_