Prescriber Criteria Form Monjuvi 2026 PA Fax 4057-A v2 010126.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) human immunodeficiency virus (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 (FL)? [If no, then no further questions.]	Yes	No
5	Is the disease relapsed or 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:_____