Docetaxel

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name:_____
Specialty: _____ **NPI#:**_____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

What is the ICD-10 code: _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Docetaxel SGM 1091-A – 06.2024.

Criteria Questions:

1. What is the diagnosis?

❒ Anal cancer, *Continue to 2*

❒ Bladder cancer, *Continue to 2*

❒ Breast cancer, *Continue to 2*

❒ Carcinosarcoma (malignant mixed Mullerian tumors), *Continue to 2*

❒ Cervical cancer, *Continue to 2*

❒ Clear cell carcinoma of the ovary, *Continue to 2*

❒ Epithelial ovarian cancer, *Continue to 2*

❒ Esophageal and esophagogastric junction cancer, *Continue to 2*

❒ Ewing's sarcoma, *Continue to 2*

❒ Fallopian tube cancer, *Continue to 2*

❒ Gastric cancer, *Continue to 2*

❒ Grade 1 endometrioid carcinoma, *Continue to 2*

❒ Head and neck cancer (including very advanced head and neck cancer, cancers of the lip (mucosa), oral cavity, salivary gland, oropharynx, hypopharynx, nasopharynx, glottic larynx, and supraglottic larynx), *Continue to 2*

❒ Low-grade serous carcinoma, *Continue to 2*

❒ Malignant germ cell tumor residual disease, *Continue to 2*

❒ Malignant sex-cord stromal tumor, *Continue to 2*

❒ Mucinous carcinoma of the ovary, *Continue to 2*

❒ Non-small cell lung cancer (NSCLC), *Continue to 2*

❒ Occult primary tumor (cancer of unknown primary), *Continue to 2*

❒ Osteosarcoma, *Continue to 2*

❒ Primary carcinoma of the urethra, *Continue to 2*

❒ Primary peritoneal cancer, *Continue to 2*

❒ Prostate cancer, *Continue to 2*

❒ Small bowel adenocarcinoma, *Continue to 2*

❒ Small cell lung cancer, *Continue to 2*

❒ Soft tissue sarcoma (including angiosarcoma, extremity/body wall, head/neck, retroperitoneal/intra-abdominal, pleomorphic rhabdomyosarcoma, dermatofibrosarcoma protuberans (DFSP) with fibrosarcomatous transformation, dedifferentiated chordoma, and solitary fibrous tumor), *Continue to 2*

❒ Thyroid carcinoma-anaplastic carcinoma, *Continue to 2*

❒ Upper genitourinary tract tumor, *Continue to 2*

❒ Urothelial carcinoma of the prostate, *Continue to 2*

❒ Uterine neoplasm (including endometrial carcinoma and uterine sarcoma), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Is patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to 3*

❒ No, *Continue to 4*

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

4. What is the diagnosis?

❒ Anal cancer, *Continue to 19*

❒ Bladder cancer, *No further questions*

❒ Breast cancer, *Continue to 5*

❒ Carcinosarcoma (malignant mixed Mullerian tumors), *No further questions*

❒ Cervical cancer, *Continue to 21*

❒ Clear cell carcinoma of the ovary, *No further questions*

❒ Epithelial ovarian cancer, *No further questions*

❒ Esophageal and esophagogastric junction cancer, *No further questions*

❒ Ewing's sarcoma, *Continue to 16*

❒ Fallopian tube cancer, *No further questions*

❒ Gastric cancer, *No further questions*

❒ Grade 1 endometrioid carcinoma, *No further questions*

❒ Head and neck cancer (including very advanced head and neck cancer, cancers of the lip (mucosa), oral cavity, salivary gland, oropharynx, hypopharynx, nasopharynx, glottic larynx, and supraglottic larynx), *No further questions*

❒ Low-grade serous carcinoma, *No further questions*

❒ Malignant germ cell tumor residual disease, *No further questions*

❒ Malignant sex-cord stromal tumor, *No further questions*

❒ Mucinous carcinoma of the ovary, *No further questions*

❒ Non-small cell lung cancer (NSCLC), *No further questions*

❒ Occult primary tumor (cancer of unknown primary), *No further questions*

❒ Osteosarcoma, *Continue to 17*

❒ Primary carcinoma of the urethra, *Continue to 15*

❒ Primary peritoneal cancer, *No further questions*

❒ Prostate cancer, *No further questions*

❒ Small bowel adenocarcinoma, *Continue to 18*

❒ Small cell lung cancer, *No further questions*

❒ Soft tissue sarcoma (including angiosarcoma, extremity/body wall, head/neck, retroperitoneal/intra-abdominal, pleomorphic rhabdomyosarcoma, dermatofibrosarcoma protuberans (DFSP) with fibrosarcomatous transformation, dedifferentiated chordoma, and solitary fibrous tumor), *No further questions*

❒ Thyroid carcinoma-anaplastic carcinoma, *No further questions*

❒ Upper genitourinary tract tumor, *Continue to 14*

❒ Urothelial carcinoma of the prostate, *Continue to 13*

❒ Uterine neoplasm (including endometrial carcinoma and uterine sarcoma), *No further questions*

5. Will the requested medication be given as adjuvant therapy?

❒ Yes, *No Further Questions*

❒ No, *Continue to 6*

6. Will the requested medication be given as preoperative therapy?
❒ Yes, *No Further Questions*
❒ No, *Continue to 7*

7. Will the requested medication be used as a substitute for other taxanes (e.g., paclitaxel or albumin-bound paclitaxel) due to medical necessity?
❒ Yes, *No Further Questions*
❒ No, *Continue to 8*

8. What is the patient's human epidermal growth factor receptor 2 (HER2) status?
❒ HER2-positive, *Continue to 9*
❒ HER2-negative, *Continue to 11*
❒ Unknown, *No further questions*

9. Will the requested medication be given in any of the following regimens (with or without endocrine therapy)?
❒ In combination with pertuzumab and trastuzumab, *Continue to 10*
❒ In combination with trastuzumab, *Continue to 10*
❒ None of the above, *Continue to 10*

10. What is the clinical setting in which the requested medication will be used?
❒ Recurrent unresectable disease, *No further questions*
❒ Metastatic disease, *No further questions*
❒ The patient has had no response to preoperative systemic therapy, *No further questions*
❒ Other, please specify. _____, *No further questions*

11. Will the requested medication be given in any of the following regimens?
❒ As a single agent, *Continue to 12*
❒ In combination with capecitabine, *Continue to 12*
❒ None of the above, *Continue to 12*

12. What is the clinical setting in which the requested medication will be used?
❒ Recurrent unresectable disease, *No further questions*
❒ Metastatic disease, *No further questions*
❒ The patient has had no response to preoperative systemic therapy, *No further questions*
❒ Other, please specify. _____, *No further questions*

13. What is the clinical setting in which the requested medication will be used?
❒ Metastatic disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

14. What is the clinical setting in which the requested medication will be used?
❒ Metastatic disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

15. What is the clinical setting in which the requested medication will be used?

❒ Recurrent disease, *No further questions*

❒ Metastatic disease, *No further questions*

❒ Other, please specify. _____, *No further questions*

16. What is the clinical setting in which the requested medication will be used?

❒ Relapsed disease, *No further questions*

❒ Progressive disease, *No further questions*

❒ Metastatic disease, *No further questions*

❒ Other, please specify. _____, *No further questions*

17. What is the clinical setting in which the requested medication will be used?

❒ Relapsed disease, *No further questions*

❒ Refractory disease, *No further questions*

❒ Metastatic disease, *No further questions*

❒ Other, please specify. _____, *No further questions*

18. What is the clinical setting in which the requested medication will be used?

❒ Advanced disease, *No further questions*

❒ Metastatic disease, *No further questions*

❒ Other, please specify. _____, *No further questions*

19. What is the patient's disease histology?

❒ Squamous cell carcinoma, *Continue to 20*

❒ Non-squamous cell carcinoma, *Continue to 20*

20. What is the clinical setting in which the requested medication will be used?

❒ Unresectable locally recurrent disease, *No further questions*

❒ Metastatic disease, *No further questions*

❒ Other, please specify. _____, *No further questions*

21. What is the clinical setting in which the requested medication will be used?

❒ Persistent disease, *Continue to 22*

❒ Recurrent disease, *Continue to 22*

❒ Metastatic disease, *Continue to 22*

❒ Other, please specify. _____, *Continue to 22*

22. Will the requested medication be used as a single agent?

❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment, *No further questions*

❒ Subsequent treatment, *No further questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com