CVS/caremark™

2211 Sanders Road, Northbrook, IL 60062 Phone (866) 814-5506

Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}
To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (855) 330-1720

Re: Prior Authorization for {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}

Electronically (4-5 **minutes** process time)	Phone (10-15 **minutes** process time)	Fax (24-72 **hours** process time)
CVS/Caremark now accepts PA requests on-line 24/7. No fax machines, no phone hold times, faster approval. Most requests will not require a fax or phone call. To request a Prior Authorization online, navigate to https://provider.carefirst.com/providers/home.page and click on the orange tab in the upper right hand corner; or for more details about how to submit and review your prior authorization requests online, view the training video available at www.carefirst.com/learninglibrary > Pharmacy.	Calling us with your PA request during our business hours is another option The process over the phone can take between 10 and 15 minutes. OR online	You may also continue to fax us your PA request Faxes received are processed within 24 to 72 hours. OR online

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Eligard

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's 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*

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

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Criteria Questions:

Please indicate the strength of the product being requested: ❑ 7.5mg ❑ 22.5mg ❑ 30mg ❑ 45mg

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Prostate cancer (*If checked, go to 23*)

❒ Recurrent salivary gland tumors (*If checked, go to 2*)

❒ Gender dysphoria (*If checked, go to 7*)

❒ Other, please specify _____ (*If checked, no further questions*)

2. Is the request for continuation of therapy?

❒ Yes, *Continue to 3*

❒ No, *Continue to 5*

3. Has the patient experienced clinical benefit while receiving the requested drug?

❒ Yes, *Continue to 4*

❒ No, *Continue to 4*

4. Has the patient experienced an unacceptable toxicity while receiving the requested drug?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

5. Will the requested drug be used as a single agent?

❒ Yes, *Continue to 6*

❒ No, *Continue to 6*

6. Is the tumor androgen receptor positive?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

7. Is the patient less than 18 years of age?

❒ Yes, *Continue to 8*

❒ No, *Continue to 9*

8. Is the requested medication prescribed by, or in consultation with a provider specialized in the care of transgender youth (e.g., pediatric endocrinologist, family or internal medicine physician, obstetrician-gynecologist) that has collaborated care with a mental health provider?

❒ Yes, *Continue to 9*

❒ No, *Continue to 9*

9. Are the patient's comorbid conditions reasonably controlled?

❒ Yes, *Continue to 10*

❒ No, *Continue to 10*

10. Is the patient able to make an informed decision to engage in treatment?

❒ Yes, *Continue to 11*

❒ No, *Continue to 11*

11. Has the patient been educated on any contraindications and side effects to therapy?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Is the request for continuation of therapy?
❒ Yes, *Continue to 18*
❒ No, *Continue to 13*

13. Has the patient been informed of fertility preservation options?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Is the requested drug prescribed for pubertal hormonal suppression in an adolescent patient?
❒ Yes, *Continue to 15*
❒ No, *Continue to 16*

15. Which Tanner stage of puberty has the patient reached?

❒ Tanner stage I (*If checked, no further questions*)

❒ Tanner stage II (*If checked, no further questions*)

❒ Tanner stage III (*If checked, no further questions*)

❒ Tanner stage IV (*If checked, no further questions*)

❒ Tanner stage V (*If checked, no further questions*)

❒ Unknown (*If checked, no further questions*)

16. Is the patient undergoing gender transition?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Will the patient receive the requested drug concomitantly with gender-affirming hormones?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

18. Has the patient been informed of fertility preservation options before the start of therapy?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Is the requested drug prescribed for pubertal hormonal suppression in an adolescent patient?
❒ Yes, *Continue to 20*
❒ No, *Continue to 21*

20. Which Tanner stage of puberty has the patient reached previously?

❒ Tanner stage I (If checked, *no further questions*)

❒ Tanner stage II (If checked, *no further questions*)

❒ Tanner stage III (If checked, *no further questions*)

❒ Tanner stage IV (If checked, *no further questions*)

❒ Tanner stage V (If checked, *no further questions*)

❒ Unknown (If checked, *no further questions*)

21. Is the patient undergoing gender transition?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. Will the patient receive the requested drug concomitantly with gender-affirming hormones?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

23. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 24*
❒ No, *No Further Questions*

24. Has the patient experienced clinical benefit while receiving the requested drug (e.g., serum testosterone less than 50 ng/dL)?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. Has the patient experienced an unacceptable toxicity while receiving the requested drug?
❒ Yes, *No Further Questions*
❒ No, *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)**