Fulvestrant-Faslodex

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

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

Criteria Questions:

1. What is the diagnosis?

❒ Breast cancer, *Continue to 2*

❒ Endometrial carcinoma, *Continue to 11*

❒ Low grade serous ovarian carcinoma, *Continue to 6*

❒ Uterine sarcoma, *Continue to 14*

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

2. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 3*
❒ No, *Continue to 4*

3. Is there evidence of disease progression or an unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

❒ Recurrent disease, *Continue to 5*

❒ Advanced disease, *Continue to 5*

❒ Metastatic disease, *Continue to 5*

❒ Other, please specify. _____, *Continue to 5*

5. What is the patient's hormone receptor (HR) status? ***ACTION REQUIRED***: Please attach chart note(s) or test results of hormone receptor (HR) status.

❒ Positive ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Negative ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Unknown, *No further questions*

6. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 10*
❒ No, *Continue to 7*

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

❒ Recurrent disease, *Continue to 8*

❒ Other, please specify. _____, *Continue to 8*

8. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Has the patient previously received an aromatase inhibitor (e.g., letrozole, anastrozole, exemestane)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

10. Is there evidence of disease progression or an unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

11. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 13*
❒ No, *Continue to 12*

12. Will the requested medication be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

13. Is there evidence of disease progression or an unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

14. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 17*
❒ No, *Continue to 15*

15. Does the patient have low-grade endometrial stromal sarcoma (ESS), adenosarcoma without sarcomatous overgrowth, or estrogen receptor/ progesterone receptor positive (ER/PR+) uterine sarcoma?

❒ Yes, low-grade endometrial stroma sarcoma (ESS), *Continue to 16*

❒ Yes, adenosarcoma without sarcomatous overgrowth, *Continue to 16*

❒ Yes, ER/PR+ uterine sarcoma, *Continue to 16*

❒ No, *Continue to 16*

16. Will the requested medication be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

17. Is there evidence of disease progression or an unacceptable toxicity while on the current regimen?
❒ 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)**

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