Imfinzi

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'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*

What is the ICD-10 code? _____

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

 Imfinzi SGM 1820-A – 02/2025.

Site of Service Questions (SOS):

A. Where will this drug be administered?
- ❑ On Campus Outpatient Hospital, *continue to B*
- ❑ Off Campus Outpatient Hospital, *continue to B*
- ❑ Home infusion, *skip to Criteria Questions*
- ❑ Physician office, *skip to Criteria Questions*
- ❑ Ambulatory surgical, *skip to Criteria Questions*
- ❑ Pharmacy, *skip to Criteria Questions.*

B. Is the patient less than 14 years of age?
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to C*

C. Is the patient receiving provider-administered combination oncology therapy or other provider-administered drug therapies at the same visit? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to D*

D. Is this request to continue previously established treatment with the requested regimen?
- ❑ No – This is a new therapy request (patient has not received 6 months or more of requested regimen). ***ACTION REQUIRED: Please attach supporting clinical documentation.*** *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of existing treatment (patient has received requested regimen for 6 months). ***ACTION REQUIRED: Please attach supporting clinical documentation.*** *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of an existing treatment (patient has received requested regimen for 7 months or greater – initial 6 months plus 45 days grace period), *Continue to E*

E. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre- medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to F*

F. Has the patient experienced severe toxicity requiring continuous monitoring (e.g. Grade 2-4 bullous dermatitis, transaminitis, pneumonitis, Stevens-Johnson syndrome, acute pancreatitis, primary adrenal insufficiency aseptic meningitis, encephalitis, transverse myelitis, myocarditis, pericarditis, arrhythmias, impaired ventricular function, or conduction abnormalities)? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to G*

G. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to H*

H. Does the patient have severe venous access issues that require the use of a special intervention only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to I*

I. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation. ❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to J*

J. Are ***all*** alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) **greater than** 30 miles from the patient's home? ***ACTION REQUIRED: If Yes, please attach supporting documentation.***
❑ Yes, *Continue to Clinical Criteria Questions* ❑ No, *Continue to Clinical Criteria Questions*

Criteria Questions:

1. Has the patient experienced disease progression while on PD-1 or PD-L1 inhibitor therapy (e.g., Opdivo)?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. What is the diagnosis?

❒ Non-small cell lung cancer (NSCLC), *Continue to 3*

❒ Extensive-stage small cell lung cancer (ES-SCLC), *Continue to 17*

❒ Hepatocellular carcinoma, *Continue to 21*

❒ Biliary tract cancer (gallbladder cancer, intrahepatic/extrahepatic cholangiocarcinoma), *Continue to 27*

❒ Cervical cancer, *Continue to 32*

❒ Ampullary adenocarcinoma, *Continue to 37*

❒ Esophageal, Esophagogastric Junction and Gastric Cancer, *Continue to 43*

❒ Pleural mesothelioma, *Continue to 50*

❒ Endometrial cancer, *Continue to 55*

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

3. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 4*
❒ No, *Continue to 9*

4. Which of the following applies to the patient's disease?

❒ Unresectable stage II or III disease, *Continue to 6*

❒ Recurrent disease, *Continue to 8*

❒ Advanced disease, *Continue to 8*

❒ Metastatic disease, *Continue to 8*

❒ Resectable disease, *Continue to 5*

5. How many cycles, after surgery, of the treatment has the patient received?

_____cycles, *Continue to 7*

6. How many months of treatment has the patient received?

_____months, *Continue to 7*

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

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

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

❒ Advanced disease, *Continue to 14*

❒ Metastatic disease, *Continue to 14*

❒ Recurrent disease, *Continue to 14*

❒ Unresectable Stage II or Stage III disease, *Continue to 13*

❒ Resectable disease, *Continue to 10*

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

10. Will the requested medication be used as neoadjuvant treatment in combination with platinum-containing chemotherapy and continued as adjuvant treatment after surgery as a single agent?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is the tumor negative for epidermal growth factor receptor (EGFR) mutations and anaplastic lymphoma kinase (ALK) rearrangements? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results of the absence of EGFR mutations and ALK rearrangements.

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

❒ No, *No further questions*

❒ Unknown, *Continue to 12*

12. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

13. Has the disease progressed following concurrent platinum-based chemotherapy (e.g., cisplatin, carboplatin) and radiation therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

14. Will the requested medication be used in combination with tremelimumab-actl (Imjudo) and platinum-based chemotherapy (e.g., cisplatin, carboplatin)?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Is the tumor negative for epidermal growth factor receptor (EGFR) exon 19 deletion and L858R mutation and anaplastic lymphoma kinase (ALK) rearrangements? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or test results of the absence of EGFR exon 19 deletion and L858R and ALK rearrangements.

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

❒ No, *No further questions*

❒ Unknown, *Continue to 16*

16. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

17. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 18*
❒ No, *Continue to 19*

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

19. Will the requested medication be used in combination with etoposide and either carboplatin or cisplatin followed by single agent maintenance?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. What is the place in therapy in which the requested medication will be used?

❒ First-line treatment, *No further questions*

❒ Subsequent treatment, *No further questions*

21. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 22*
❒ No, *Continue to 23*

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

23. Will the requested medication be used in any of the following regimens?

❒ Single agent, *Continue to 24*

❒ In combination with tremelimumab-actl (Imjudo), *Continue to 24*

❒ Other, please specify. _____, *Continue to 24*

24. What is the place in therapy in which the requested medication will be used?

❒ First-line treatment, *Continue to 25*

❒ Subsequent treatment, *Continue to 25*

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

❒ Unresectable disease, *Continue to 26*

❒ Metastatic disease, *Continue to 26*

❒ Other, please specify. _____, *Continue to 26*

26. Is the patient eligible for transplant?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

27. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 28*
❒ No, *Continue to 29*

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

29. Will the requested medication be used in combination with cisplatin and gemcitabine?
❒ Yes, *Continue to 30*
❒ No, *Continue to 30*

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

❒ Locally advanced disease, *No further questions*

❒ Unresectable disease, *No further questions*

❒ Resected gross residual (R2) disease, *No further questions*

❒ Metastatic disease, *No further questions*

❒ Recurrent disease, *Continue to 31*

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

31. Did the disease recur after surgery and adjuvant therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

32. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 33*
❒ No, *Continue to 34*

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

34. Is the requested medication being used to treat small cell neuroendocrine carcinoma of the cervix (NECC)?
❒ Yes, *Continue to 35*
❒ No, *Continue to 35*

35. Will the requested medication be used in combination with etoposide and either cisplatin or carboplatin?
❒ Yes, *Continue to 36*
❒ No, *Continue to 36*

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

❒ Persistent disease, *No further questions*

❒ Recurrent disease, *No further questions*

❒ Metastatic disease, *No further questions*

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

37. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 38*
❒ No, *Continue to 39*

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

39. What is the place in therapy in which the requested medication will be used?

❒ First-line treatment, *Continue to 40*

❒ Subsequent treatment, *Continue to 40*

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

❒ Unresectable disease, *Continue to 41*

❒ Metastatic disease, *Continue to 41*

❒ Other, please specify. _____, *Continue to 41*

41. What is the disease type?

❒ Pancreatobiliary disease, *Continue to 42*

❒ Mixed type disease, *Continue to 42*

❒ Other, please specify. _____, *Continue to 42*

42. Will the requested medication be used in combination with cisplatin and gemcitabine?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

43. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 44*
❒ No, *Continue to 46*

44. How many doses has the patient received?

_____doses, *Continue to 45*

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

46. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming microsatellite instability-high or mismatch repair deficient tumor status.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 47*

❒ No, *Continue to 47*

❒ Unknown, *Continue to 47*

47. Will the requested medication be used as neoadjuvant treatment?
❒ Yes, *Continue to 48*
❒ No, *Continue to 48*

48. Will the requested medication be used in combination with tremelimumab (Imjudo)?
❒ Yes, *Continue to 49*
❒ No, *Continue to 49*

49. Is the patient medically fit for surgery?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

50. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 51*
❒ No, *Continue to 52*

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

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

❒ Unresectable disease, *Continue to 53*

❒ Other, please specify. _____, *Continue to 53*

53. What is the place in therapy in which the requested medication will be used?

❒ First-line treatment, *Continue to 54*

❒ Subsequent treatment, *Continue to 54*

54. Will the requested medication be used in combination with pemetrexed and either cisplatin or carboplatin?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

55. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 56*
❒ No, *Continue to 57*

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

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

❒ Advanced disease, *Continue to 58*

❒ Recurrent disease, *Continue to 58*

❒ Other, please specify. _____, *Continue to 58*

58. Will the requested medication be used in combination with carboplatin and paclitaxel followed by use as a single agent?
❒ Yes, *Continue to 59*
❒ No, *Continue to 59*

59. Is the tumor deficient mismatch repair (dMMR)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming deficient mismatch repair tumor status.

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

❒ No, *No further questions*

❒ Unknown, *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